

# PSYCHO-ANALYSIS

*A Handbook for  
Medical Practitioners and Students  
of Comparative Psychology*

by  
EDWARD GLOVER, M.D.



S T A P L E S   P R E S S

STAPLES PRESS LIMITED  
Mandeville Place, London

STAPLES PRESS INCORPORATED  
70 East 45th Street, New York





SECOND EDITION 1949

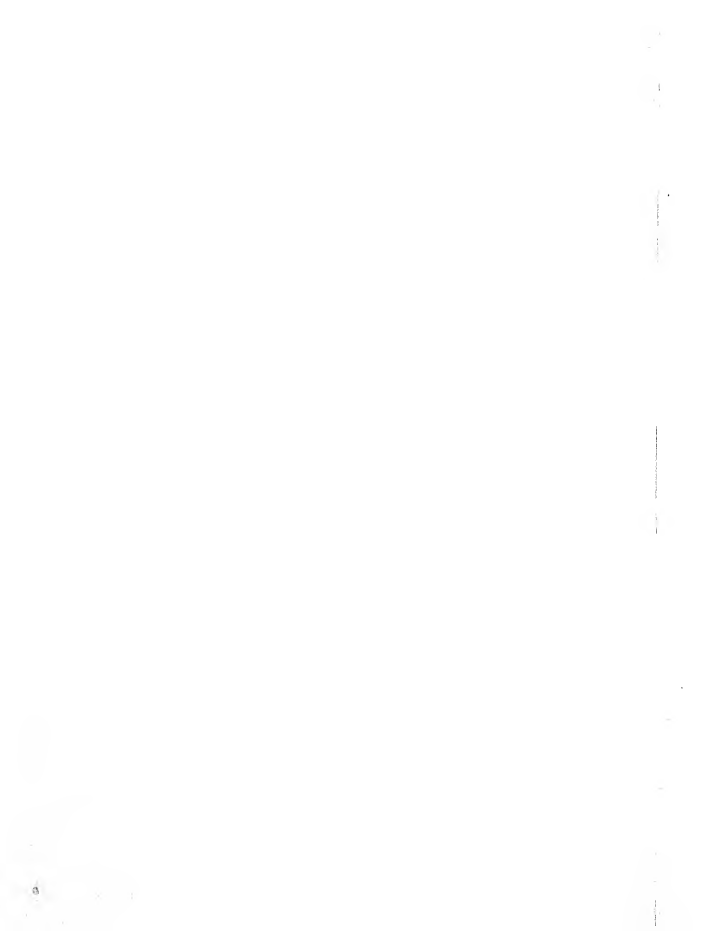
*Copyright Reserved*

THIS BOOK IS SET IN  
10 ON 11 POINT 'MONOTYPE' TIMES NEW ROMAN



*Made and printed in England by*  
STAPLES PRESS LIMITED  
*at their Kettering, Northants, establishment*

TO THE MEMORY OF  
SIGMUND FREUD



## CONTENTS

<i>Chapter</i>	<i>page</i>
PREFACE TO SECOND EDITION	9
PREFACE TO FIRST EDITION	11
I INTRODUCTORY	13
<i>SECTION I</i>	
<i>Theory of Psycho-analysis</i>	
II THE EMBRYOLOGY OF MIND	22
III THE DYNAMIC ASPECTS OF MIND	33
IV THE STRUCTURE OF MIND	51
V THE ECONOMICS OF MIND	67
VI PHASES OF MENTAL DEVELOPMENT	95
VII DREAMS AND SYMPTOMATIC ACTS	109
VIII SYMPTOM FORMATION	122
<i>SECTION II</i>	
<i>Clinical Psycho-analysis</i>	
IX INTRODUCTORY	136
X PSYCHO-NEUROSES	139
XI PSYCHO-SOMATIC AND ALLIED DISORDERS	170
XII PSYCHOSES	202
XIII TRANSITIONAL GROUPS	243
XIV PSYCHOSEXUAL DISORDERS	250
XV SOCIAL DIFFICULTIES	264
XVI PSYCHO-ANALYSIS OF CHILDREN	280
<i>SECTION III</i>	
XVII PRACTICAL APPLICATIONS	299
APPENDIX	333
GLOSSARY	341
LIST OF BOOKS RECOMMENDED	349
INDEX	353



## PREFACE TO THE SECOND EDITION

The preparation of a Second Edition of this book has afforded me the opportunity of expanding it in two directions. Being no longer hampered by the necessity of producing a 'pocket monograph', I have developed the presentation at a number of points where it suffered from over-condensation. I have also endeavoured to bring the account of psycho-analysis up-to-date. Partly as a result of war conditions but mainly because of a diminution of the impetus towards psycho-analytical research, few extensions of psycho-analytical psychology can be recorded during the past ten years. Such progress as has been made has been in the direction of filling in 'gaps' left by Freud during his own sweeping advances. Since however the impact of war-time psychiatry has led to a general reaction in favour of superficial (pre)conscious factors in mental disorder, I welcome the opportunity of re-stating the basic theory of psycho-analysis to which modern clinical psychology owes whatever vitality it may possess.

1948 *EDWARD GLOVER*



## PREFACE TO THE FIRST EDITION

The task of condensing the theory and practice of psycho-analysis within the space available in a monograph series is by no means easy. It is hoped that the present outline will give the practitioner some idea of the existing scope and future possibilities of this science. For obvious reasons stress has been laid on what might be called the more conventional aspects of clinical psychology, such as, for example, the somatic manifestations of psychic disorder. Some indication has been given, however, that clinical psycho-analysis concerns itself with a number of subjects which are not usually regarded as medical. Indeed it is no exaggeration to say that it has advanced the frontiers of medicine to include many of the territories of individual and social psychology. In so doing it has added considerably to the labours and responsibilities of the general practitioner.

1939 *EDWARD GLOVER*





## INTRODUCTORY

Although the incidence of psychological disorders in general practice has never been accurately estimated, it is generally recognised that they are of extremely common occurrence. Lack of accurate statistical information is due to two main factors, first, that the symptoms of conversion hysteria are in many cases difficult to distinguish from the symptoms of organic disease, and, second, that little or no systematic training in psycho-pathology is given at medical schools. It is only natural therefore that, for example, a gastric neurosis (or, more accurately, a conversion hysteria disturbing gastric function) should be labelled in the first instance as a purely organic disease, or that, say, a dysmenorrhoea or amenorrhoea associated with organic pelvic disorder should be regarded as having no psychological significance. There is no doubt however that in whatever form psychological disorders may appear, whether as pure neuroses, or as psychological complications of organic illness, they provide the general practitioner with some of the most harassing of his therapeutic problems. No matter how exhaustively he may examine his patient, or how sedulously he may apply different methods of organic treatment, the physician may find himself faced with a 'negative therapeutic reaction.' To put it quite simply the patient obstinately refuses to get well. Partly for this reason and partly because the name itself suggests a technical method, psycho-analysis is regarded by most practitioners simply as *one of a number of therapeutic methods* to which recourse may be had when the more customary procedures of organic medicine have been tried without success.

The popular association of psychotherapy with the names of Freud, Jung and Adler is calculated to reinforce this somewhat restricted view. It is, of course, true that psycho-analysis was originally developed by Professor Freud as a method of treating the psycho-neuroses, in particular hysteria and the obsessional neuroses; and it is still the most radical procedure that can be adopted in such cases. But within the last twenty-five years it has come to be applied to a great variety of abnormalities of character, to a number of social and sexual difficulties, to the mental disorders of children, and, in more recent times, to various forms of psychosis, particularly the manic-depressive group. During the same period the number of so-called normal individuals investigated by means of psycho-analysis has greatly increased. By dint of comparing the observations made in normal and abnormal cases respectively

it has been established that *so-called normal individuals present minor symptom-formations which in a more exaggerated form would certainly be regarded as classical symptoms of neurosis or psychosis*, or contrariwise, that even the *most bizarre symptoms of mental disorder are, in a sense, caricatures of normal mental mechanisms or formations*. These findings are readily confirmed by the study of a number of peculiarities in conduct or reaction which lie between the apparently normal and the glaringly abnormal. Many inhibitions of work and disorders of social capacity are of this nature: for example, pathological shyness or querulousness. These reactions lie between the sensitiveness of apparently normal persons and the more glaring interferences with social function that can be observed in hysteria or in psychotic states. Many transient depressions belong to the same transitional group and, especially when associated with acute or chronic toxæmia, may give rise to mistaken diagnosis. It is true such cases are rarely observed in hospital practice and are consequently rarely demonstrated to medical students or post-graduates: they are however a frequent source of difficulty in general practice either because the patient's unrecognised psychic conflicts interfere with his social and working capacities and so delay his return to active life or because they directly retard his recuperation from ordinary organic illness.

This *overlap between normal and abnormal mental function* in adults has been rendered much more comprehensible as the result of psycho-analytical research into the mental processes of children during the first five years of life. Behaviour and emotional reactions which, if observed in a grown-up, would be regarded as distinctly abnormal are often and rightly discounted as the natural manifestations of early childhood. Moreover by means of this *developmental approach* the early psycho-analytical view has been amply confirmed, namely, that the mental disorders of adolescence and adult life are based on disturbances occurring during infancy and early childhood. This view was originally expressed in Freud's aphorism: *no adult neurosis without an infantile neurosis*. And although this saying does not allow for the infantile character reactions which are the forerunners of adolescent and adult psychosis, it serves to emphasise not only the importance of developmental factors in mental disorders, but the fact that no hard and fast line exists on the one hand between the mental reactions of normal children and of mentally disordered adults or on the other between those of abnormal children and of apparently normal adults. Nevertheless in clinical practice definite and useful distinctions *can* be drawn and it is essential in the interests of both diagnostic and prognostic accuracy that they should be made.

A further and equally fruitful result of psycho-analytic observation of children has been the foundation of what might be called *diagnosis-*

*in-depth*. This procedure which is rarely applied in the case of adult organic disease, except in the attenuated form of an anamnesis, is essential to the accurate assessment of adult mental disorder. Unless we can establish the nature of anxiety manifestations exhibited by the patient during childhood we cannot, without further and sometimes prolonged observation, estimate the variety, depth and tractability of his adult anxiety states.

The developmental approach has also given great impetus to the *classification of mental disorders*. Broadly speaking, psychotic disturbances of adult life indicate that serious disorder of the ego has existed during the first three years of life; whereas the psychoneuroses of adult life suggest that the course of infantile psycho-sexual development between the age of roughly three to six years has been seriously disturbed. Following these lines of approach a number of etiological formulae have been established for different mental disorders; and although much remains to be done in this direction, it is now possible to solve many diagnostic and prognostic problems by using psycho-analytical standards of assessment. In short psycho-analysis is not only a method of mental treatment, it provides a *technique of research* on the normal and abnormal functions of the mind, and thereby leads to a more accurate and useful classification of mental disorders in terms of their developmental significance.

But psycho-analysis is more than a mere diagnostic, therapeutic or research instrument. *The formulations it has arrived at constitute a theory of mind*. The development of *metapsychology*, to use the term by which Freud indicated that mental function depends on factors that cannot be detected in the field of consciousness, was his most outstanding contribution to mental science. That he was able to develop a complete theory of mind from clinical observations of mental disorder was due to the fact that from the beginning, Freud operated with certain basic conceptions which enabled him to describe psychic phenomena without departing from biological criteria. Thus his theory of mental structure and function is based on the old physiological *concept of a reflex arc*. Mind corresponds to the *central system* of this arc, a system whose function it is to regulate excitations arriving by afferent paths and to secure as far as possible their appropriate discharge through efferent channels. By adopting this analogy, mind can be regarded as an instrument or *apparatus* and can be thought of as having a psychic locality and *structure*, which can then be sub-divided into a number of component parts (*mental institutions*). This constitutes the *topographic* approach to the problem.

A second, *dynamic* approach is concerned with the *excitations* that disturb this central system. Mental activity is a response to disturbances of equilibrium. These disturbances arise out of (1) the stimulations

of (for the most part) unsatisfied instincts, (2) the psychic discomforts which follow or threaten to follow rise or fall of instinctual energy. Activities due to instinct-tension may manifest themselves either as mental experiences (thoughts or feelings) or through bodily (motor and sensory) innervations of which the mind also takes cognizance. Psychically regarded, these motor innervations constitute what is termed behaviour or conduct.

Mental activity can also be regarded as an *economic* process. The economic aspects are governed by a general tendency of the psychic apparatus to master such instinct excitations as cannot be immediately discharged and in consequence threaten a variety of discomforts, one of the most compelling of which is described as anxiety. Guided by what is called the *pleasure-pain principle* the mind seeks to reduce stimulation to an optimum level and, in the case of undischarged excitations, it achieves this purpose through a number of unconscious *mechanisms*. These may provide a substitute discharge in which the original aim of the instinct disappears; or, they may control the excitation by distributing it over various qualitatively different systems; or again, they may inhibit the energy as near as possible to source. Some of these economic manoeuvres have satisfactory results: others have not. When the result is considered satisfactory both by the individual and the community, the individual is by common consent regarded as *normal*. Normality is essentially a pragmatic standard, indicating that the individual has achieved a working balance between the claims of his own instincts and the standards of behaviour laid down by himself and by the community in which he lives. A not inconsiderable advantage of the economic approach to mental function is that it enables the observer to study the problems of psychic disorder relatively free from common or even professional prejudice. Many trained psycho-therapists, not excluding some psycho-analysts, have no real feeling for a metapsychological approach. Their natural reaction is either to consider each case in terms either of *illness* or of a *conflict* between conscious and unconscious drives. By so doing they lose sight of the part played by mental disorder in the total function of the personality. Actually, *neuroses and other mental disorders are simply forms of unsatisfactory (inappropriate, unrealistic) discharge which occur when the individual has been unable to achieve a working balance between his instinct - tensions and the outlets permitted them either by himself or by his social environment.*

These three approaches, the topographic, the dynamic and the economic, are essential to the full understanding of every mental event. Nevertheless each observer is likely to follow his own preferences in the matter of approach. Many can appreciate the dynamic and economic aspects of mind but are quite unable to grasp the concept of mental

topography. This difficulty can be overcome to some extent by thinking of mind in *temporal* rather than spatial terms. Temporally regarded, it is a series of more or less characteristic events occurring between the phenomena of stimulation and those of discharge. The function of these events, both popularly and scientifically regarded, is to secure and maintain peace of mind and body.

A reproach commonly levelled at psycho-analysis is that its terminology is obscure and apparently verges on a form of jargon. This is a reproach from which the physical sciences are almost entirely immune. The terminology of biochemistry, for instance, is much more complicated than that of psycho-analysis, yet no exception is taken to this inevitable expansion of a physical science. No doubt immunity from this criticism is more readily accorded the physical sciences because the layman is neither disposed nor encouraged to claim competence in these subjects; whereas both layman and general physician are naturally inclined to exert their 'authority' on psychological matters. In any case it is certain that as psycho-analysis progresses its terminology will become more rather than less complex. In many respects the state of psychological medicine today is comparable to that of organic medicine at the time when the circulation of the blood was discovered. The great mental systems or organs of the mind have been isolated and their general functions established. These conceptions have already been turned to service in building up broad classifications of mental abnormalities. But the time will no doubt come when mental mechanisms and disturbances of function will be as closely subdivided as is at present the case with disturbances of physiological function. As in other sciences, a number of basic concepts are employed (compare, for example, the terms 'neural energy' and 'psychic energy'), but these concepts are merely conveniences to be adapted to the needs of the science. In many instances the terms used by psycho-analysts have been taken from current speech and given a scientific connotation e.g. the use of the term 'repression' or 'complex.' But the same practice is adopted in natural science as, for example, when the term 'wave' is used in physics. Psycho-analysis is essentially an empirical science and has made a practice of discarding old conceptions or building up fresh ones as the occasion demands.

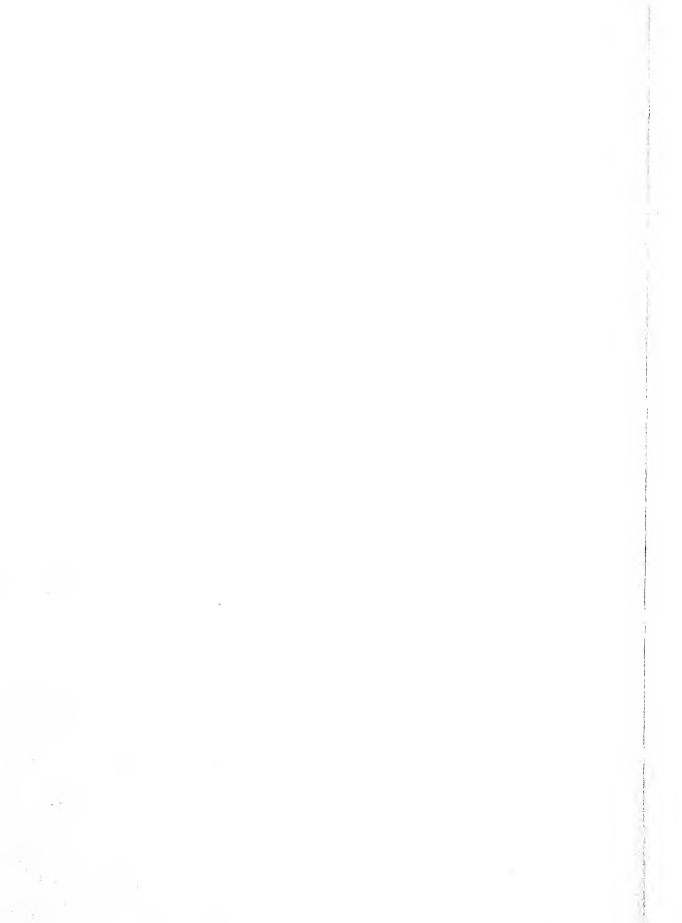
Space does not permit a lengthy discussion of the intimate relation of theory to practice but it may be said that an adequate grounding in the structure and function of the normal mind is as necessary to the clinical psychologist as a knowledge of anatomy and physiology is to the organic physician. Owing to the fact that psycho-analytic treatment is a highly technical procedure and that its practice involves a specialized and lengthy form of training, the role of the general practitioner is of necessity limited to making an accurate diagnosis of mental disorder

at the earliest possible moment and of recommending the form of treatment that appears to be most suitable. These aims can be achieved only if the practitioner is oriented as to the nature of normal mental activity. On the other hand it has to be admitted that just as a good physiologist may not necessarily make a good clinician, so an over-exclusive concern with the theory of mental function may blunt clinical understanding. As in organic medicine, it is essential for the medical psychologist to understand not only the etiology of a symptom but the part it plays in *the total function of the individual*. Above all it is essential to understand the *meaning* of a mental symptom. Neurotic and other mental symptom-formations differ from organic dysfunctions in that they have psychic significance. The simplest forms of conversion-hysteria e.g. attacks of indigestion or constipation, are not simply functional abnormalities to be summed up in relation to other metabolic processes. They also have a meaning, which once recognized, is as intelligible as any form of everyday speech, thought or behaviour. Indigestion, for example, may be a gesture of aversion or repudiation, constipation an expression of the anxiety of separation. Whether they are expressed in mental or in physical form, *mental disorders are essentially end-products, patterns of feeling, thought and behaviour*. However distorted and disguised they may appear, they represent *mental policies* arrived at in an endeavour to resolve conflict between the inner drives or wishes of the individual and the possibility or desirability of securing gratification of these wishes in real life. They are in this sense adaptations of the individual to his environment although, in view of the suffering they entail both to the individual and to those in intimate contact with him, they might justifiably be called *mal-adaptations*. The peculiarity and apparent lack of meaning of these manifestations is, however, due not solely to the elaborate disguises they assume but also to the fact that the drives responsible for them are unconscious. Moreover, the patterns of these maladaptations are laid down during infancy, and are for the most part inaccessible to processes of introspection. Hence it is desirable to preface any systematic description of normal structure and function by outlining in non-technical terms the mental development which takes place in the first five or six years of human life, in so far as this can be inferred from observation, reconstructed by anamnesis or discovered by psychoanalysis.

The second chapter of this book is an attempt at such a non-technical reconstruction. It is followed by an outline of the theory of normal mental function (Chapters III, IV and V) at the end of which the developmental outline is repeated in more technical terms, (Chap. VI). Although of necessity highly condensed, these outlines may provide a serviceable introduction to the study of symptom-formation. (Chaps.

VII and VIII). It should be added that no attempt is made to argue the validity of psycho-analytical views or to give the evidence on which they are based. The terms used or definitions given are limited to those which have stood the test of time. Controversial views have been omitted or have been specifically referred to as controversial. Readers who wish to acquire more detailed information on the theory of psycho-analysis should refer to the standard text books on the subject, a selection from which is given at the end of this book.





## *SECTION I*

### THEORY OF PSYCHO-ANALYSIS

The Embryology of Mind.  
The Dynamic Aspects of Mind.  
The Structure of Mind.  
The Economics of Mind.  
Phases of Mental Development.  
Dreams and Symptomatic Acts.  
Symptom Formation.

*Chapter II*

## THE EMBRYOLOGY OF MIND

To be a good clinical psychologist it is necessary to understand not only that mental illness is a form of maladaptation and that satisfactory adaptation depends on a successful weathering of the first five years of life, but also that the process of 'growing up' is one of the most remarkable of human achievements. For within those first five years every infant has to abandon an almost animal state of existence in favour of civilized reactions that were established only after thousands of years of painful racial experience. When the pace of this civilizing process is too hot for the infant or when his primitive instincts are too strong, trouble is certain to brew. Either the infant is compelled to make premature adaptations to society, as represented by the grown-ups in the family, in which case a precocious but essentially weak ego develops: or, in the case where primitive instincts are powerfully charged, the ego is retarded in development and is unable to cope with or master the excitations to which it is subjected. It is at this point that constitutional factors exert their maximum influence, in particular the capacity to withstand frustration. Indeed considering that the factor of frustration is constant, the wonder is not that neuroses are so common, but that major mental disorders are not universal.

Although these generalisations are in the nature of inferences from the behaviour of the infant, it is easy to confirm them by study of anthropological data. Actually some understanding of the mentality and habits of primitive tribes is a useful preamble to the everyday practice of medical psychology. If the physician understands how much babies, savages *and* civilized grown-ups have in common, he will not be surprised to find that the normal mental reactions of a two-three year old can scarcely be distinguished from the magical and animistic systems of savages or from the obsessional practices and superstitions of the civilized neurotic: or again, that the precautionary anxieties, self-punishments and organic dysfunctions of the European hysteric are of the same order as the incest taboos, punishments and precautionary rituals of primitive societies. And he will be the more ready to believe that these systems of reaction can be traced to the peculiar conditions of infantile development through which every human being must pass.

Little can be said with certainty about some of the most revolutionary stages in mental evolution, the dawn of consciousness or the development of self-consciousness. Apart from behaviouristic studies of infants

in the first few weeks of life, no opportunities exist for direct investigation of these phenomena. Animal behaviour, even in domesticated apes, permits only the most sketchy of inferences, and, however deeply we analyse the minds of children or savages, we find primitive psychic mechanisms already in operation, behind which it has so far proved impossible to penetrate. We may assume, however, that man's earliest psychic reactions developed in response to violent disturbances of instinct, in particular frustration caused by acute environmental stresses. And no doubt the sexual instincts were the first to contribute to these developments, since these are by far the most labile of instincts and most capable of enduring frustration. Capacity to endure delay in gratification or to secure substitute gratification is one of the characteristics distinguishing man from the other mammals. And it is no mere coincidence that *incapacity to endure frustration of the more primitive instincts is universal amongst sufferers from mental disorder*.

There are, of course, many other distinguishing characteristics. The behaviour of man like that of other animals is to a considerable extent determined by *fear*: and *simple anxiety* explains much that would otherwise be incomprehensible in his conduct. But there is a peculiar modification of fear which specifically characterizes man's behaviour and is invariably present in the more primitive layers of his mind. It is best described by the term *guilt*. Now guilt cannot exist until the infant mind divorces fear from its external associations and establishes by some means or another a fear of its own self which necessarily implies a fear of the strength of its own impulses. And this in turn involves some degree of consciousness of self. But, although we cannot describe with certainty how *the development of self-consciousness went hand in hand with the isolation of a vast unconscious territory of the mind*, we now know enough about this unconscious mind to explain the origin of guilt and the animistic character of early mental activity. Wild animals are always ready to react with fear to their environment, but they do not manufacture their own fears. On the whole their instinctive reactions are appropriate to the reality dangers with which they are faced. The infant, however, practically from the time it draws breath, develops states of terror which the observer knows to be groundless. Of course, the external world does confront the newly born baby with a massed battery of new and often excruciating stimuli, which can be justifiably regarded as real sources of fear. Nevertheless the curious fact remains that for some fateful years after birth he is not adequately reassured by the security from real external danger which the family actually provides. In course of time it becomes clear that the most intense of his fears are aroused by those very persons whose function it is to afford him protection. For although the infant sometimes reacts to some members of his family as if they were safe, at other times they,

like the rest of his environment, may become the target of his most lively apprehensions.

The sequence of events, the argument, so to speak, in the baby's mind is as follows. Owing to inevitable and increasing frustrations of instinct, there exists in him a state of painful tension which is reacted to with rage and terror. Although it would not be accurate to suggest that the infant has as yet any sense of moral responsibility, the situation can best be described by saying that he blames the environment for his disagreeable experiences and thinks that it hates him in the same way that he hates it. He believes it to be as malignant towards him as he feels towards it. Supposing, for instance, he is hungry and there is some delay between the feeling of hunger and the sight of food, or between the sight of food and the satisfaction of hunger, his desire is mingled with rage and gives rise to veritably cannibalistic impulses. He wants to bite the breast that feeds him. Supposing then that suckling is followed by a colic (or, when, in time, it is followed by weaning) his pains (or frustrations) are interpreted as acts of revenge or punishment on the part of the mother, (more accurately, on the part of her nipples). She has injured him as he wished to injure her or her nipples. The infant has then two causes for hating and fearing the mother: the real frustration of needs and wishes which he has experienced and the imaginary hostility to himself which he inevitably ascribes to her. (see *projection*). But since many infantile frustrations are unavoidable and since infantile hate is comparatively ineffective, and in any case disturbs the enjoyment of what infantile love can be secured, life with this double source of hatred and fear is altogether too painful.

What cannot be endured must be cured. Either the infant must bring about changes in the environment or he must learn to regulate his own reactions to environment and so reduce the states of tension that arouse fear and hostility. Now the infant's capacity to alter his environment is very strictly limited. It is true that he can to some extent bribe or intimidate his guardians into affording him more gratification. But experiences soon teach him that blandishments are not to be depended on and that although demonstrations of rage occasionally produce good results, they are even more likely to lead to increased frustration if not actual punishment. And so his energies are directed to mastering his own states of excessive excitation. *He develops a number of psychic mechanisms to assist him in his emotional impasse.* No doubt these mechanisms are derived from inherited psychic tendencies, but they are already well established before their operation is detected by the observer. Some differences of opinion exist as to the order of emergence of these mechanisms but there is no doubt that from very early times the child can exploit a capacity for 'active forgetfulness' or '*oblivescence*' a mental 'turning-away' (see *repression*) by which it

may succeed to some extent in remaining unaware, not only of its own frustrated impulses, but of any discomfort arising from their frustration. True, it will still desire to eat and will complain if hungry, but the love and hate components of its cannibalistic systems can be obliterated, and may then give no indication of their presence except in the form of functional eating difficulties.

In the second place the baby develops a capacity to endure *partial gratification* and to accept *substitute gratifications* for its frustrated instincts. The acceptance of partial gratifications is based originally on the economic principle that half-a-loaf is better than no bread: but the process is accelerated by the fact that with increasing elaboration of its sources of pleasure, *new* varieties of pleasure help to compensate for the diminution or loss of older pleasures. A primitive form of this process can be observed in the nutritional functions whereby a lesser and yet more complicated pleasure (thumb-sucking) helps to carry the child through the experiences of temporary and permanent weaning. But in true substitution the instinct is wholly transferred from one object to another. In place of the original objects, or more accurately organs, loved and hated, the baby transfers the frustrated interest or reaction to remoter ones which have the merit of being, or appearing to be, less immediately disastrous to it (see *displacement*). It is not exactly a case of half-a-loaf being better than no bread: rather there are times when a string of beads may be better than half-a-loaf; better because the original source of frustration, and therefore of anxiety and hate, is completely obliterated and because frustration of the new interest does not provoke such violent reactions.

All these manoeuvres do not, however, solve the infant's problem. Permanent flight, whether by forgetting or by accepting substitutes, is rarely successful in dealing with an internal stress that is constantly renewed, and projection alone would leave the child in a world full of enemies. The kettle steaming on the nursery hob, the movement of curtains, lights and shadows, whispered voices or the back-fire of a passing taxi would have a perpetually malignant meaning for him. But at this point yet another device can be employed, one which for the first time offers him a permanent escape from his dilemma although at considerable cost to his energies. Partly misled by a primitive tendency to feel that objects (organs) contributing to his pleasure are part of himself, and at the same time exploiting a capacity to feel 'at one with' the organs (or objects) he loves (values), but which are nevertheless the same objects he has both real and unreal reason to hate, *he now reacts as if these objects were part of himself* or, to use purely psychical terminology, *part of his mind or ego*. (see *introjection and identification*).

It is a kind of radical 'make believe,' a philosophical outlook, as it

were, the extreme example of which is solipsism. Nevertheless it produces a profound and permanent change in the child's mind. And this for two reasons. The more he succeeds in taking the object of any given instinct into his own ego, the more capable he is of abandoning the object of that particular instinct. Expressed in dynamic rather than topographic terms, he becomes capable of abandoning the particular instinct that is directed at the original object. But since this instinct was already in process of frustration, thereby setting up reactions of hostility to the object, the more the child abandons his instinctual drive, the less occasion there is to experience hostility to the object. As however the object has been set up as part of his own ego, the abandoned hate is also withdrawn or, more accurately, reflected back on himself. Here it can be used for a variety of purposes but mainly in the interests of self-inhibition. And self-inhibition is an additional safeguard against directing unbridled impulses towards family objects.

In the second place by adsorbing the object of a particular instinct, the child's mind is no longer its own. It is split into two parts a 'self-self' and a 'parent-self'; for, as has been pointed out, the objects of the child's most important instincts are represented by parents who control gratification. These, now separate 'parts' of the ego may love each other or hate each other. If the 'self-self' is 'good' it will feel loved by the 'parent-self' and vice versa. If the 'self-self' is 'bad' it will feel hated or disapproved of by the 'parent-self' and vice-versa. The system has two advantages. A good deal of frustrated love towards parents can be effectively employed in the form of self-enhancement. But even more important the child's hatred has been split, and turned on itself. *This revolutionary manoeuvre is the first to put an effective brake on his primitive and frustrated instincts, including the hate impulses aroused secondarily by frustration.*

To recapitulate: the attribution of internal hatred to imaginary external enemies is not enough, because it encourages an unbridled display of passion against objects that are comparatively harmless and in any case are the main external sources of love. When, however, mainly through the need for love, the mind modifies a part of itself so that this part comes to represent parental influences and when already the child has attributed the most draconic severities to these parents, hate impulses have been hoist with their own petard. The stronger and more painful these impulses are, the more they have to be projected; the more they are projected the more dangerous and tyrannical the parents appear to be. Hence, the more the child begins to feel 'one with' the powerful parents the more it has sold itself into slavery; it now feels bound to disapprove of and control its own primitive drives. The intensity of its disapproval and the rigour of its control depend on two factors. Having internalised the role of the

parent, the child is bound to disapprove of its own frustrated impulses to the same extent as it formerly felt (sometimes rightly enough) that the parents disapproved of its primitive drives. And having withdrawn into itself the hatred of the object that was caused by frustration it must now hate its own primitive drives with the same intensity as it formerly hated the object of its frustrated impulses. *In this way a sense of guilt is established.* The child's aggressive impulses have been turned (played off) against themselves: *the way is open for a friendlier and freer communication with the external world.*

Nevertheless the system has its disadvantages. The 'parent-self' may become too powerful and tyrannical. It may induce excessive inhibition and damp down vital energies to a point that is almost suicidal; or it may give rise to such painful feelings of internal guilt that a fresh projection is necessary. The child must somehow get rid of its own sense of sin, and does so by allocating the blame to the external world which is then felt to be wicked rather than dangerous and therefore worthy of punishment. The child has now three causes to fear and attack the external world: first, that the external world does really attack the child to some extent all the time – a real cause this; second, that in any case the child projects its own asocial impulses on to the external world and expects to be attacked by it – an unreal cause of fear and hatred; and third, that having tried to swallow and digest these real and unreal fears the child, as it were, mentally regurgitates the painful nexus and tends to disapprove of and attack the external world all the more severely because it now believes itself to be virtuous in so doing, as indeed in part it is.

As in the case of the other manoeuvres described, these early splittings of the ego and introversions of impulse are unconscious processes and are already well established before the observer detects their end-products. But it is easy to infer the history of the process from observation of quite simple forms of child's play. When a child takes to repeating painful experiences of frustration, playing at the same time the role of frustrator and frustrated, it is obvious that its mind has already been split. And it is easy to infer that the process of splitting must begin to take effect at some point between the successful weathering of early frustrations and the appearance of obvious and spontaneous signs of instinct inhibition. And this roughly speaking occurs when the child first shews signs of developing 'character'. Character is indeed a necessary by-product of inhibition. As has been indicated, differences of opinion exist as to the order of emergence of primitive mechanisms. But these differences are not capable of immediate resolution since practically all re-constructions of early phases of development are in the nature of guesses at probability and are strongly influenced by the prejudices and preconceptions of the observer. The consensus of psycho-



analytical opinion is however in favour of the order given in this account. In any case the isolation of mechanisms is a conceptual device mainly imposed by the necessity for intelligible presentation. No psychic mechanism operates in a state of isolation.

It is safe to say however that by the time the ego shews obvious signs of permanent differentiation, the infant has already completed the first half of the average five-year span of infantile life. Though, of course, infantile time is not measured by clocks, but by the recurrence of different varieties of emotional experience. Babies pass through many lives in the twenty-four hours and in the infantile table of measures a calendar month may vary in time value from eternity to a split second. But the more accurate the realistic measures become the quicker time passes. Little enough remains in which to cover the vulnerable organisation the infant has built up. For the next year or so he is extremely busy wrapping this sensitive mind round with protective layers, the most important of which are made up of superstitions, beliefs and observances, rituals of thought, work and play. These at the same time help to control his danger-causing impulses, reassure or neutralize his animistic fears and pave the way for an expansion of reality relations to life.

Of course, even the youngest infant has a good reality sense of a kind appropriate to his surroundings. And, reinforced by the development of conceptual thinking, power of speech and freedom of play, this reality sense steadily expands. Some observers, carried away by their enthusiasm for reconstructing the phantasy life of the infant have omitted to take account of the reality factors in child-development together with their biological determinants and have incorrectly assumed that the earliest forms of conceptual thinking are essentially phantastic interpretations of (what the observer knows to be) reality. But this view has not gained currency outside a small group. No doubt the process of reality expansion is *in the long run* reinforced by the same animistic and superstitious reactions which cause him so much trouble. For his anxieties about the external world provoke a sharpened interest in it, and once these anxieties have been alleviated a 'decontaminated' residuum of reality knowledge remains. Just as astrology led to astronomy, so an infant's animistic fear of dirt may later be neutralised by obsessional play with coloured chalks, and lead finally to acquiring the realistic uses of writing. Anyhow, the last stage of the developmental process commences when between four and five years of age, the total thrust of infantile instinct begins to die away. The mind dons its outermost protective garments which are essentially systems of comparatively rational thought and action. (See also *rationalisation*). And because these systems are hailed with obvious relief by the family and in any case mark his delivery from primitive strains, the infant begins and

continues throughout life to over-estimate the virtues and powers of his rational thought.

The foregoing description of the early phases of mental development has so far been confined to an outline of early mental mechanisms and of the structural alterations they bring about. The fact has also been emphasised that the process of isolating mechanisms and structures is a conceptual device employed by the observer. At every stage of psychic development, the control of instinct is the result of the *total function* of the psyche. To avoid confusion only the most general reference has been made to the particular instincts that are subject to frustration at any given stage. From the point of view of psychic economy and structure it is sufficient to say that instinctual frustration of whatever variety together with the painful affects it produces constitute the compelling force that sets these mechanisms in operation and ends in differentiation of psychic structures.

Nevertheless it is desirable to bear in mind the diversity of instinctual stresses to which the child's mind is subject. And this for three reasons: first, that it gives some indication of the nature and intensity of frustration at different stages; second, that it explains why the child's mind becomes increasingly capable of dealing with stresses by means of unconscious mechanisms: and, third, that it gives a clue to the unconscious mental content at different periods. The third point has an important clinical bearing. Unconscious content varies according to the disorder examined and is therefore of service in differential diagnosis.

From the point of view of mastery of instinct, infantile development can be conveniently divided into two main phases. During the first two-and-a-half years (these figures are of course mere approximations, since the urgency of instincts and the precocity of ego-development vary from individual to individual) nutritional, excretory, skin and muscular functions dominate life. Yet during the same period the instincts derived from these bodily sources must undergo the most profound modification. Weaning does not, it is true, abolish the aim of feeding but it abolishes its first object (nipple or bottle); the aim and object of excretion is not altered but its spontaneous gratification is controlled. What then contributes to these remarkable feats of renunciation and mastery? The answer is that these processes apart from subserving the aims of self-preservation give rise to pleasure experiences which Freud was quick to recognise as essentially sexual in nature. Although the self-preserved impulses of the child cannot be abandoned except under direct stress, the accompanying sexual impulses can be and are abandoned or controlled. And so the way is gradually paved for more radical frustrations. Indeed the factors that contribute most to mental development are the lability of sexual drives and their capacity to withstand frustration or to accept substitute-gratifications.

The development of infantile sexuality so far from being an unwarranted aspersion on the character of the infant (as early critics of Freudian theories so readily assumed) is thus seen to be a psycho-biological prerequisite of normal development.

But although the development of early psychic structures and mechanisms, accelerated as it is by the motor freedoms of walking and speech, reaches a point during the second year, when for the first time the mental apparatus can be regarded as organised, permanent organisation of mental processes is not achieved until the second period namely from two-and-a-half to five years. Synthesis of the ego cannot be established until the child's relations with external objects are themselves synthesised. The first phase is, as it were, a period of preparation for the second. During the second phase an almost adult flowering of impulse takes place. The child is plunged into situations of love, jealousy and hatred towards its parents in which genito-sexual impulses play a part that is perfectly obvious to the trained observer. These are not precisely the same as the sexual situations of adolescence and adult life. They are not only immature but are accompanied by primitive forms of anxiety and guilt. Nevertheless they represent a much more personal reaction to external objects and so constitute a nodal point in development. The mastery and effective abandonment of incestuous impulse plays as important a part in the history of the individual as it did in the history of the race. During the second phase the mental apparatus assumes its final form. And once the incestuous phase has been finally abandoned the synthesis of the newly formed ego proceeds apace.

Incidentally it is of some historical interest to note that whereas the older descriptive psychologies placed these processes of integration at much too late a period, associating them almost exclusively with adolescence and early adult life, some dynamic psychologists have proceeded to the opposite extreme. Basing their reconstructions of early mental life on their own postulates – for naturally it is not possible to obtain analytical evidence until the child is of an age that permits controlled analytical technique – they have assumed that the infant's struggles with aggressive impulses call the incestuous phase into existence already in the first half of the first year of life and so give rise to organised forms of psychic structure. These views have not been accepted in psycho-analytical circles and are no doubt due to a misreading of the mental content to be found in children old enough to be analysed.

The conclusion to be drawn by the clinical psychologist from this, necessarily disjointed, account is the following: – *many of the syndromes of adult mental disorder are simply repetitions of (regressions to) developmental stages and mechanisms, which being isolated and magnified, appear*

*in grotesque contrast to the more rational adult structure.* Childhood disorders are more difficult to detect for the simple reason that they are to some extent cloaked by the peculiar privileges accorded the child by society. He is often permitted and sometimes encouraged to behave or express himself in ways which in the case of an adult would be promptly stigmatised as neurotic, psychotic or delinquent.

But to grasp the more human aspects of symptomatic regression it is necessary to be familiar with the small child's ideological systems. As has been pointed out the infant has from the first a reality system appropriate to the conditions of life in which it finds itself, but as development proceeds, and as thought-processes become organised, a distinction can be drawn between ideas that focus round reality experiences of pleasure and pain and phantasies that are developed as a response to complete frustration of instinct. These systems of unconscious phantasy have no doubt a compensatory function to perform although the gratification obtained by this means is at best marginal. Even so it is heavily discounted by the anxieties and, later, guilts to which unconscious phantasies give rise. Phantasy formation is fostered by periodic regressions from waking to sleeping life and by numerous misreadings of waking experience to which the small child is naturally prone. So that whilst there is an *appropriate system of reality thinking for each phase* of development, these systems are increasingly infiltrated or at any rate unconsciously associated with *phantasy systems that are also appropriate to the stage of instinctual frustration at which the child has arrived.* It is reasonable to suppose that once conceptual processes develop the child seeks to explain his outer and inner world in terms appropriate to himself, a habit which the adult has by no means abandoned. Thus the bars of the cot against which the infant strikes himself may be a number of malignant mothers whom he attacks and who at the same instant strike him back. His thumb may be a mother-god to be alternately sucked and bitten or a father-god to be adored; a piece of tinkling glass may promise him ecstatic communion with the cosmos. Later, every recognisable object in the nursery is alive and according to his mood menacing or friendly. His inside is possessed of demons or sometimes of angels. Still later when his instinctual drives to his parents are beginning to take on a more mature form, he has the most phantastic theories of the nature of sexual relations and of baby-making. These vary in accordance with the prevailing form of infantile interest. Babies are made of the solids, liquids or gases of which the child has corporeal experience. Impregnation takes place by eating; parturition by defaecation or vice-versa. Some forms of love threaten death to himself and to his love-objects. Differences between the sexes are the result of a primitive form of surgery carried out by the parents on children or by the father on the mother. Some forms of hate

although even more dangerous may have acquired a 'love value' and so cannot be abandoned. In short his phantasies are not to be dismissed as grotesque forms of thought or as isolated unconscious wish-formations; woven together they constitute a theory of life – a *Weltanschauung*, a philosophy, natural history, biological speculation and sooner or later a religion. Occasionally fragments of these systems remain on the surface of the mind, but these are merely deserted outposts of more extensive and archaic systems concealed underneath. *It is those concealed systems which, activated again in adult life, precipitate illness.*

But should the physician find this reconstruction too implausible, and it must seem highly unlikely that a placid child gazing out of the nursery window is the repository of such complex and disturbing ideas, there is still a way open by which sympathetic contact can be made with mental disabilities of all ages. It is to remember that the child's list of developmental achievements is an impressive one. By the end of the first five years he has weathered internal storms of love and hate; sustained hurts and disappointments; accommodated himself to an environment which is not only painfully inadequate to his hopes and fears but which, with the best or worst of intentions, may have behaved stupidly, even brutally, to him. Despite these difficulties he has overcome to a large extent his boundless fears, has throttled down large charges of primitive and unteachable instinct and has directed large quantities of instinct to new goals. Moreover – and this is perhaps the most remarkable of human achievements – he has succeeded in splitting some of his more primitive energies and has converted them into a more or less neutral form in which they can with reasonable luck be diverted towards more adapted aims. (See *sublimation*). These are achievements of which the average adult is totally incapable. *Mental disabilities deserve to be regarded with sympathetic understanding; they represent the price paid in later life for over-rapid or ill-consolidated victories over baby instincts.*

## Chapter III

## THE DYNAMIC ASPECTS OF MIND

Psycho-analysis is first and last a dynamic psychology. There are of course many varieties of dynamic psychology, all of which are based to some extent on the *concept of psychic energy*. The common use of terms such as 'urge', 'drive', 'impulse', 'compelling motive,' even 'force of character' imply that the layman is nothing if not a dynamic psychologist. Nevertheless it is essential to distinguish carefully between dynamic concepts that are suitable only for the purposes of conscious psychology and dynamic concepts that are congruous with the discovery of the unconscious mind. In this sense Freud's psychology is the most dynamic of all psychologies. *The concept of instinct is a root-concept of psycho-analysis*. To this day heated controversies centre round the validity of this concept and its applicability to psychic affairs. But the psycho-analyst although theoretically interested in such discussions does not allow himself to be deflected thereby from the formulation of working concepts that help him to account for and to treat the clinical disorders with which he is in daily contact. It should be understood therefore that the following account of mental forces or energies is based essentially on working hypotheses.

**INSTINCTS.** Instinct in psycho-analysis is a boundary concept between the organic and the psychic. Although the nature of instincts is not yet fully understood, instinctual processes are presumably traceable in the last resort to changes in the physico-chemical economy of the body. These are referred to as the *sources* of instinct. From the mental point of view instincts are regarded as quantities of continuous psychic stimulation (excitation), to be distinguished from the more intermittent sensory stimulations (experiences) that impinge on the central nervous system and are subsequently interpreted by the psychic apparatus. Instincts are most easily thought of in terms of flow (or rise and fall) of *energy*. They have *aims*, contributing to ultimate gratification and *objects* towards which the aims of the instinct are directed. The aims of instinct are not readily altered, but their objects can be and frequently are changed. Sexual instincts are capable of change as regards both aim and object. Classification of instincts is usually effected in terms of source, aim or object; as for example, 'oral impulses' where the *source* lies in the mouth zone; 'masochistic impulses', where the *aim* is to enjoy attack at the hands of an external object; and 'positive incestuous impulses' where the instinct is directed at the *object* (parent)

of the opposite sex. In all cases differentiation is arrived at by studying the individual's thoughts, feelings, speech and actions. Certain feeling  $\rightarrow$  thought  $\rightarrow$  action *sequences* can be observed which promote an 'end result' of gratification or discharge of tension and from which the nature of the instinct is inferred. Disturbance of this sequence produces some variety of mental and (or) physical discomfort. Thus, in the case of hunger, the instinct frustrated is that variety of the instinct of self-preservation which is expressed through the impulse to eat food. The tension arising from frustration of this particular instinct can be experienced, bodily, in the form of gastric discomfort or 'hollowness', affectively, in the form of impatience or irritation and, ideationally, in the form of images of food and thoughts concerned with obtaining food. These thoughts are then followed by various motor activities calculated to secure food, chew, swallow and digest it. Of the last of these bodily manoeuvres the mind may take comparatively little cognizance unless pleasurable or painful experiences ensue. Psycho-analysts favour simple rather than complicated groupings of instinct. They are content with a working division into sexual impulses (or love impulses) using this term in its widest sense, and aggressive impulses. Even the self-preserved impulses are regarded as a specialised form of love-impulse (see *narcissism*); although, clinically speaking, it is easy to observe that they exercise a good deal of independent action, and that, except in situations of severe and prolonged stress, their aim and object are not capable of modification. Deeper investigation shows that this apparently over-simple grouping is justified. It is a plausible assumption that any instinct, disturbance of which is sufficient to cause mental or physical breakdown, must be of cardinal importance. *In the last resort most psychic disorders can be traced back to disorders of the sexual and aggressive impulses, or perhaps more accurately, to disturbances in the equilibrium of love and hate.*

**SEXUAL INSTINCTS.** Although analysts use the word 'sexual' in an extremely broad sense and refer to the energy of these instincts as *libido*, there is no vagueness about the manifestations in question. There are three main varieties of sexual excitation. (1) *Adult sexual instinct* universally recognised at puberty and responsible for the manifold and manifest love and reproductive phenomena of adult life. (2) *Infantile sexual impulses* existing from birth, gradually organised during the first two years of life and reaching a peak in the fourth and fifth years, after which they either gradually or suddenly disappear. (The fallow period between infantile and pubertal forms of sexuality is called the *latency period*. It varies considerably in length). (3) *Libidinal excitation* (charges) existing in the various tissues and organs of the body, giving rise to the so-called *organ* or *body libido*. Each of these

three forms of sexuality plays a part in the etiology of the neuroses and psychoses. Disturbance of normal adult instinct is not as a rule responsible for mental breakdown, but if prolonged or severe, it is an extremely common precipitating factor. It can however produce a number of psychic reactions (anxiety, irritability) and somatic disturbances mostly of a sensory type (sense of pressure, physical fatigue) which can interfere with the individuals function and well-being. (see *actual neuroses*). Major disturbances of infantile sexual instinct are invariably present in both neuroses and psychoses. Excessive rise or fall of organ libido is a factor in neurosis, especially in the conversion-hysterias and actual neuroses. It is still more important in the psychoses.

*Adult Sexual Instinct.* Comprehensive study of the manifestations of adult sexual and reproductive drives is essential to a proper understanding of all adult psychological disorders or crises. Nevertheless two pitfalls should be avoided: (1) to regard adult sexuality as the sole or root cause of mental breakdown. (2) To limit the term to manifest erotic components of sexuality. The psychic accompaniments of sexual activity, in particular, feelings of love, tenderness, appreciation, security and the enhancement of self-feeling, are of the greatest significance. Disturbance of these feelings is a very common *precipitating* cause of mental breakdown. Inasmuch as very similar feelings exist during childhood and contribute greatly to the psychic security of the child, disturbance of the psychic accompaniments of adult sexuality is an even more urgent precipitating factor than the frustration of adult erotic urges. In regard to direct erotic manifestations there are three points to be noted. (1) That disturbances of normal sexual rhythm, e.g., excessive courting without adequate physical satisfaction or excessive masturbation without adequate outlet for tender relations with love-objects, may give rise to various forms of anxiety. (2) That the varieties of erotic fore-pleasure solicited prior to coitus give some hint as to the earlier distribution of infantile sexual interest. (3) That the numerous forms of aberration of adult sexuality, e.g., perversions, fetishism, etc., are in themselves indications of conflict over earlier (infantile) forms of sexuality. They should not be regarded simply as curiosities or solely as the result of constitutional deviations.

*Infantile Sexuality and Body Libido.* Infantile sexuality consists of a number of *component* instincts. These are frequently named after the body-zone from which the excitations are derived. The three most important sources of infantile sexual interest are the *oral*, the *anal* (and *urethral*) and the *genital* zones. Although all these interests exist from birth, each of the three zones in turn exercises a *primacy* over the others – a fact of importance in estimating the depth of etiological



factors in all mental disorders. During each of these phases all the love interests of the child, its unconscious phantasies of gratification and its theories as to the love activities of parents are heavily biased by its experience of its own predominating libidinal needs. It should be remembered, of course, that, although some of these phantasies and wish-formations are conscious, by far the greater proportion are and remain permanently unconscious (see *Psychic Systems*). Thus during the later stage of primacy of the oral (or suckling) phase the infant's phantasies might well be described as cannibalistic in type (sucking, biting, tearing, swallowing, etc.) In fact the oral stage is commonly divided into two phases, an early pre-dentition or sucking phase and a later biting phase that commences with teething. Where oral primacy is marked, oral phantasy tends to recur in later childhood, when, for example, the unconscious (and frequently conscious) theory exists that the sexual relations of the parents and impregnation take place through the mouth. In the later more organised anal phases love is phantasied in appropriate terms of anal intimacy and of excretory activities. The anal stage is likewise divided into two phases, an early rejection phase and a later phase of mastery and control. The birth of children, always a focal point in the child's psycho-sexual interest, is assumed to take place by an act of defaecation. In the genital stage love is phantasied in terms of infantile genital theory. These genital phantasies resemble in content the realities of adult sexual life but are more primitive, inaccurate and unrealistic. For example, the possession of a penis by the opposite sex is part of the boy's natural philosophy, a view with which the girl agrees, accounting for her own lack of this organ on the ground that it has been taken away as a punishment. So strongly does interest in the male organ dominate infantile genitality, that Freud described this stage as the *phallic phase*. While the phallic interests of the boy can be understood without effort, the corresponding interest of the little girl must be correlated with the activities of the clitoral zone. Phallic interest in both sexes overlaps earlier theories as to the function of the mother's breast. This genital stage is the one originally termed the *Oedipus phase* of the child, during which the wish exists for genital relations either with the parent of the opposite sex (*positive Oedipus wish*) or with the parent of the same sex (*negative Oedipus wish*). Nowadays all infantile phases of sexuality have come to be regarded in principle as part of a *total Oedipus stage* of family relations. Although convenient enough in principle, this has given rise to a certain amount of confusion and distortion of clinical values. It is a mistake to regard the primitive and disconnected phase of oral sexuality as having any valid correspondence with the genital organisation which leads to the development of the classical Oedipus phase. Clinical investigation has confirmed the established view that the genital

Oedipus complex is the *nuclear complex* of the neuroses. Each phase of infantile sexuality has characteristic forms, arouses characteristic anxieties or guilts and has come to be associated with specific mental disorders ; e.g., hysteria is still believed to be determined specifically by conflict aroused during the phase of infantile genital primacy, and to have a special association with unconscious anxiety of sexual mutilation. In addition to these three zonal components, viz., oral, excretory and genital, the *skin* is an important source of infantile sexuality and has a specially close connection with masochistic impulse. The *musculature* is also a source of libidinal excitation and contributes largely to the sexual component of sadism. It is convenient to bracket *gastric* with oral erotism and *intestinal* with anal libido. Next in importance comes erotism of the respiratory and cardiovascular systems. Other organs and tissues are also charged with *body libido*, the existence of which can sometimes be detected by study of behaviour and phantasy, particularly hypochondriacal ideas. *The distribution of libido in the different zones and organs determines to a considerable extent the locality of hysterical conversion symptoms*, cf. the importance of respiratory erotism in hysterias of the asthma type or of skin erotism in certain eczemas. Body libido is also the main factor determining hypochondriasis.

Apart from those infantile sexual drives which are classified according to their zonal distribution, some are labelled in accordance with their aim. The most important of these are the impulses of *sadism*, *masochism*, *exhibitionism*, and *sexual curiosity*. Sadism results from the fusion of libidinal impulse with destructive impulse, the aim being to secure gratification by inflicting pain, injury, or humiliation (either physical or mental) on the love object. In masochism gratification is obtained by enduring pain, etc. at the hands of the love object. Infantile sexual curiosity has a large element of sadism. It is a strong urge to penetrate (and by this knowledge to master) the mysteries of family sexuality. It is readily associated with the active component of sexual viewing, the passive counterpart of which is represented in exhibitionism. Baffled infantile curiosity and the primitive nature of infantile sexual urges are responsible for a nexus of *infantile sexual theories*, e.g. of reproduction by sadistic coitus between the parents. Curiosity is one of the most active infantile sexual components because, in addition to its primary aims, it provides some compensation for a lack of more concrete gratifications of incestuous impulse. Originally the libido of the child endeavours to secure gratification through every form of sensory experience; taste, touch, smell, etc.; but in the long run it tends to flow into auditory and visual channels.

*Auto-Erotism and Narcissism.* — All sexual components can be subdivided according to the nature of the object to which they are attached. Two main groups can be distinguished. *Allo-erotism* refers to sexual drives which require for their gratification external objects, *auto-erotism* to sexual impulses which can be gratified by the individual without the interposition of a real external object. Infantile sexual components lend themselves readily to auto-erotic practice. As with other sexual activities a distinction has to be drawn between the physical and psychic aspects of auto-erotism. Study of the common forms of genital masturbation shews that, although the individual can induce the desired stimulation without actual objects, his accompanying sexual phantasies include a wide variety of conscious interests in sexual objects. So that, apart from its specific gratifications, masturbation can function as a compensation for the absence of object relations. It can also be a defensive regression or flight designed to protect the child against the dangers imagined to be inherent in object relations. This is of considerable clinical significance, because compensatory regressions occur when unconscious sexual phantasies of relations with incestuous (family) objects are activated. It is easy to prove that during infancy phases of compulsive masturbation occur when the child is in a state of conscious or unconscious conflict over incestuous drives. Moreover, it has been established that auto-erotism like allo-erotism is a frequent resource when the individual suffers from excessive anxiety.

*Narcissism* is a concept of a different order. As the mind distinguishes more clearly between the self and its instinctual objects a considerable amount of infantile sexual interest is found to be attached to the self; or, to put it more technically, the ego is invested with libido. This is constantly reinforced owing to the existence of body sources of sexuality, organ libido in general, and erotogenic zones in particular. This *primary* narcissistic investment increases when, in course of abandoning early incest-drives, permanent identifications with these parental objects of love and hate are set up in the child's ego (see also *Introjection Mechanisms* and *Super-ego Formation*). This process expands the ego considerably and at the same time much of the libido freed by abandonment of the incestuous object can be attached to the now expanded ego. These augmentations of ego-libido constitute what is called *secondary narcissism*. It should be remembered however that a good deal of the libido withdrawn from infantile objects becomes desexualised in the process (see *sublimation*). In this neutral form it can be re-directed, either to reinforce narcissistic aims or to add to the force of new, non-sexual object relations. The libidinal charges attached to later non-familial objects can also be withdrawn and although under normal circumstances they are capable of free displacement to still other objects, the

process of withdrawal frequently leads to some degree of permanent reduction. Whatever charges are not displaced to new objects return to the ego to swell the charge of secondary narcissism. The gradual reduction or partial abandonment of adult object-libido increases with age. Full investment of new objects is increasingly hard to achieve. This fact is quite patent in advanced age when the general libidinal interest of the individual becomes increasingly infantile and increasingly narcissistic.

Although the developments described above are in no sense abnormal, a number of pathological conditions can be traced to disturbances of narcissism. Too strong primary narcissism leads to difficulty in making early object-attachments and so prejudices healthy psychological development. This is an important source of psychotic predisposition. A variety of disorders are due to disturbances of secondary narcissism. Early and excessive withdrawal of object-libido predisposes to psychotic breakdown by increasing narcissism to an intolerable degree. Moreover should the withdrawn charges be insufficiently desexualised, pathological consequences may ensue. These can be readily detected in conditions of megalomania. In less extreme instances excessive abandonment of early object-libido diminishes the sensitiveness of the ego to object relations or alternatively sets up an unconscious regression, either predisposing the individual to homosexual fixation (objects *like* the self) or to restricted forms of heterosexual interest (heterosexual objects that present homosexual characteristics). In both instances some degree of maladjustment is likely to develop.

The isolation of a purely narcissistic phase of development is of course a conceptual device adopted by the observer for purposes of presentation. Rudimentary object relations can always be presumed even during the first year although these are unorganised and intermittent. Nevertheless the concept of a narcissistic phase is clinically valid. Until differentiation of objects is more or less permanent and effective, it is justifiable to describe the prevailing tendency of the libido as narcissistic. Controversies as to the duration of narcissistic phases have recently been provoked by attempts to regard relations with objects as being highly organised already in the first year. These attempts, which are based solely on hypothetical reconstructions, have not gained currency in psycho-analysis. Biologically regarded such hypotheses are in the highest degree questionable and would involve an entirely forced interpretation of the function of sleep, to say nothing of the function of the libido. An organism that spends the larger part of the twenty-four hours asleep and a good deal of its waking life feeding, excreting and exploring the pleasure resource of its skin, mucous membranes and musculature can fairly be regarded as narcissistic in type.

To sum up: *narcissism, as distinct from auto-erotism which is a form of sexual gratification, is a stage of organisation of the ego.* Difficulty in distinguishing between the terms is due to confusing the energies of narcissism, which are certainly libidinal, with the earliest object of the energies which is a primitive ego-form. Narcissism is a natural phase of development; indeed a period of healthy narcissism is essential to normal development.

Finally it should be emphasised that although infantile sexual energy arises from body sources, the concept of sexual energy or libido is a mental concept. It is essential to a proper understanding of mental development. Libido is actually the main factor in mental development. Those who regard mental development as in the main a consequence of frustrated aggression, which in turns calls out in the infant increasingly advanced forms of libidinal interest have failed to grasp the constructive aspects of the libido. If the huge charges of infantile libido are successfully modified and adapted to the needs of real infantile life the mind will in all likelihood develop normally. *If they are not so adapted some mental warping will ensue, and there is every probability that sooner or later the individual will fall ill.*

**AGGRESSIVE INSTINCTS.**—(Impulses of aggression, destruction and mastery).—Most analysts are ready to postulate a primary instinct of aggression which in addition to satisfying its own ends furthers the aims of other instincts, e.g. contributes the amount of aggressiveness necessary to effective love and reproduction and provides the destructiveness necessary to self-preservation. Other observers are of the opinion that aggressiveness is essentially a reactive phenomenon called into existence by states of tension, e.g. by the frustration of any other instinct. These views are not mutually exclusive. Clinical investigation has shown that (1) whether or not there be a primary instinct of aggression, the mind is radically influenced from the earliest days of life by aggressive impulses; (2) as well as contributing to normal mental development, these forces can be responsible for the most severe forms of mental breakdown; (3) aggressive impulses show a readiness to combine or fuse with and again to isolate themselves from love (sexual) impulses. Love impulses and aggressive impulses hardly ever exist in a pure state. Fusion is obvious in sadism and masochism when the manifest sexual aim includes a desire to injure or be injured by the love object. Further investigation has shown that apart from such obvious fusions, love impulses have a general tendency to combine with varying quantities of aggressive impulse. This has given rise to a somewhat slipshod use of the term sadism. Sadism is now applied to

a mixture of sexual and aggressive impulse towards objects even when there is no manifest sexual element present and when, in consequence of this, the aggressive aim appears to predominate.

Classification of aggressive impulses is not very satisfactory. Adult impulses of aggression can be described in the utmost detail and the adult varieties of sadistic perversion are not difficult to label. But these, however strongly charged, are not the varieties responsible for nervous breakdown. They function solely as precipitating factors. The most striking infantile forms are named, after the libidinal components with which they are associated, *oral*, *anal*, (or *excretory*) and infantile *genital sadism*. This zonal terminology was adopted partly because stages in the development of the libido were recognised before their close fusion with aggressive instincts was fully appreciated; but it happens to be also the most serviceable clinical classification. The concept of primacy can also be usefully applied to phases of aggression. It should be realised however that the changing primacies of sadism are due to alteration of the libidinal components. The aims of aggression, namely, destruction or mastery, do not modify. Apparent modifications are due to the fact that the technique, the mode of expression as it were, varies with the associated libidinal interest. The most primitive forms are discharged through the musculature, larynx, jaws, arms, legs etc. (screaming, crying, biting, scratching, tearing, throwing, kicking etc.) but in the earliest stages the objects against which sadism is directed are not well defined. Naturally oral sadism is directed mainly against the breasts and increases from the time of eruption of teeth. Even so the infant is not yet very clear as to the distinction between the self and objects outside the self. Hence the most violent forms of organised sadism against objects are only recognised as such in the course of the second year of life by which time oral and anal sadism overlap a good deal. The fact that control of the excretory functions is finally achieved about the same period, and that the parental objects who promote this control are by that time much more clearly defined and apprehended, means that the hostility and hatred directed at grown-ups is strongly charged with anal (excretory) sadism. Roughly speaking, difficulties with oral, anal and genital sadism are associated respectively with depressive, obsessional and hysterical symptoms. Genital sadism is also responsible for a great variety of sexual inhibitions and deflections (perversions). Difficulties with muscle-sadism are expressed in every variety of symptom from the deepest psychoses to conversion hysteria, e.g. catatonia and hysterical paralysis. Incidentally the aggression that is combined with curiosity serves to provide discharge of sadism through the intellectual processes. This fusion may give rise to conflict and so produce various neurotic or even psychotic inhibitions of intellectual processes, learning, etc.

Some masochistic expressions of aggressive instinct can be classified in the same way as the sadistic varieties. Thus it is proper to speak of *oral, anal and genital masochisms*. Contrasting these varieties with the sadistic forms and studying the zonal sources of the instincts, it becomes clear that bodily organs and zones can be sub-divided in accordance with the degree to which they promote *active or passive function*. In the case of the oral, anal and genital zones, sadistic expressions of aggression are found to be associated respectively with biting, expulsive and penetrating functions. Contrariwise the masochistic varieties are associated with the reception, retention and pressure functions of the zones in question. Again whilst sadistic aggression has a specially close relation to the musculature, masochistic forms have an equally close relation to the *skin and mucous membranes*. This is well borne out by study of adult forms of passive impulse.

The distinction between active and passive sources of instinct permits the assumption that body libido contributes to a *primary form of masochism*, a view which is also supported on clinical and theoretical grounds. And it is easy to see that the introversion of sadism and hostility that follow the frustration of early drives towards external objects must give rise to *secondary masochism*. In other words object-sadism turned back on the self ends in an increased absorption through the channels already indicated by primary masochism; masochism acts as an absorber of frustrated sadism.

Like the sadistic forms of aggression, masochistic forms are associated with specific disorders of function. Masochistic reactions play an important part in all mental disorders, in particular those which can be shewn to satisfy the unconscious need for punishment. Zonal sources of masochism also constitute seats of election in conversion hysteria. In obsessional neurosis the patient's profound absorption in moral conflict satisfies a masochistic purpose (see also the function of *moral masochism*): whilst in cases of depressive insanity, the masochistic factor is found to have affected every stage of the individual's development. When during a depression these different layers are simultaneously activated and when in addition the masochistic charges are heavily reinforced by intumed charges of sadism withdrawn from objects, the situation is grave. Attempts at suicide may be anticipated. The masochistic aspects of sexual inhibition are obviously significant.

In this summary I have used the terms sadism and aggression as if they were interchangeable. The practice is justifiable to the extent that aggression never exists in pure culture. When used in this general sense sadism should not be confused with the erotic perversion of the same term. It may be slipshod to talk of sadism instead of aggression but on the other hand it is quite wrong to think of aggression as if it had no sexual component. Again, although it may seem incongruous to make

masochism and aggression co-terminous, it is really important to recognise that masochism canalises enormous qualities of relatively pure aggression. Leaving these terminological issues aside, the outstanding fact remains that tensions of aggressive instinct are amongst the most powerful to which the human being is subject. They overcome the deepest tendencies to self-preservation much more frequently than do the tensions of sexual impulse. *Fundamentally all mental conflict consists in a struggle between love tensions, self-preservative tensions and aggressive (hate) tensions.*

*Ambivalence.* – As has been emphasised the isolation, for purposes of clinical description, of sexual and aggressive instincts may give rise to false impressions. Not only are these impulses permanently fused in the case of sadistic and masochistic perversions, but there is a constant interplay between them. This is easier to grasp when expressed in terms of the loves and hatreds of children for their parents. The child's love of and need for love from its parents is readily replaced by hate when the parents frustrate or appear to frustrate these impulses and needs. Moreover, when one parent is regarded by the child as a rival for the love of the other parent this increases the existing hostility to the parental rival. The child is then faced with the painful situation of loving and hating in rapid alternation. Sooner or later this alternation leads to a permanent mixed attitude, a simultaneous loving and hating which is called *ambivalence*. Ambivalence is subdivided in the usual way in accordance with stages – oral, anal, genital etc. It is the most constant source of mental conflict, and in the case of obsessional neurosis is the main etiological factor responsible for the disorder.

**AFFECTIVE STATES.** *Dynamic Aspects.* Active instincts manifest themselves in three ways: through *affective experiences*, through *mental images and ideations* and through *verbal and actual behaviour*. From the point of view of psychic function affective states are the most important because in accordance with their pleasureable or painful tone they prompt or compel immediate behaviour (adaptation). Affects induced directly by instinct excitation are of two kinds – tension affects and discharge affects. *Tension affects* are mostly, but not exclusively painful. Although hunger and aggression tensions have some pleasure quality this soon gives place to painful affect. Sexual tensions are sought after and maintained in the first instance because of the pleasure tone of increasing stimulation. In the absence of discharge, however, they also sooner or later develop a painful tone. *Discharge affects* are generally but not exclusively pleasureable. The amount of pleasure is in direct ratio to the amount of discharge secured. This is the most obvious in the case of hunger and love. When, however, gratification



of one impulse disturbs the gratification of another impulse, pleasure is proportionately diminished. If, for example, the activation of a primitive sexual impulse (whether conscious or unconscious) to the parent of the opposite sex appears to the child (whether consciously or unconsciously) to threaten danger to his body, and so arouses his narcissistic and self-preservative impulses; or if, owing to sexual rivalry, it stimulates destructive impulses towards the parent of the same sex (who nevertheless is a love-object in his own right, as it were) and so arouses a sense of guilt and a disproportionate need for non-sensual love and affection from both parents, the original pleasure tone of the impulse is cancelled out, and a painful tone takes its place. Under normal conditions the immediate result is inhibition or control of the pain-causing impulse. Should the impulse have already reached consciousness, it disappears, leaving no trace; if it has not so far obtained conscious expression it remains permanently unconscious. To make assurance double sure, a system of antithetical reactions is developed in consciousness which acts as an effective barrier.

This sequence of psychic events is easier to detect in the case of anal or excretory sexuality. The infant left to itself displays quite frank interest and pleasure in its excretions, playing with them in every imaginable way, not excluding tasting and swallowing. After a lapse of time these pleasure reactions are found to be replaced by reactions of disgust, and shortly afterwards the primitive interest is conspicuous by its absence. It is easy to infer that the disgust barrier is erected by the 'self-self' on the instructions of the 'parent-self': the code of behaviour to which it gives rise has indeed an obvious resemblance to the series of injunctions laid down by parents. Equally obviously the 'self-self' has accepted both external and internal injunctions and in order to carry them out mobilises all sorts of painful incentives. Frustration of any impulse causes mental pain and puts a premium on its abolition from consciousness. Should however the frustrated impulse remain active it is promptly disapproved of by the 'parent-self' and its tension becomes doubly painful. When it is further disapproved of by the 'self-self' it is trebly painful so that a primitive frustrated impulse striving to reach consciousness is opposed at every step by painful reactions.

*To understand psychological illness it is essential to grasp this sequence of events.* Thus, a *phobia* (a fixed fear of an object or idea that does not ordinarily justify fear, e.g. fear of mice or spiders, of closed spaces or of ghosts) is not simply a manifestation of fear. It indicates that a primitive wish-formation has been activated in the unconscious mind, gratification of which threatens danger or mental pain and therefore can no longer be pleasurable. It is clear however that in this case something has gone wrong either with the system of abandoning

impulse or with the system of erecting protective barriers against it, or with both. Ordinarily, painful frustrated wishes are checked as near as possible to source. But in the case of the phobia these protective manoeuvres have evidently failed. The wish is allowed to penetrate consciousness, but on condition that its true nature is not revealed, and that even in its disguised form it is painful rather than pleasurable. A great variety of psycho-neurotic and psychotic symptoms, and many psycho-sexual and characterological disorders can be explained on this basis: *they represent a form of disguised wishing and disguised discharge accompanied by or threatening painful affect.*

It must be confessed however that the classification of affects either in terms of instinctual tension and discharge, or in descriptive terms of 'pleasure' and 'pain' although essential to theoretical understanding has not reached a stage at which it is of much clinical value. The precise relation of different affects to specific components of instinct has not been very carefully worked out. The factor of instinctual fusion alone makes this task an extremely difficult one. And if, as seems probable, Freud's further suggestion proves to be accurate, namely, that different kinds of affect are induced by different quantities of the same instinct – in other words, that the rise and fall of instinct excitation may induce qualitative changes in affective response – these difficulties would appear to be almost insurmountable. On the other hand the descriptive approach is unsatisfactory not only because it depends on superficial and subjective criteria and so gives little or no indication of what is going on underneath but also because individual exploitation of pleasure and pain experiences is not easily predictable: it is greatly influenced, for example, by the amount of primary and secondary masochism in the psyche. It is true that some of the tension affects of love and hate are simple enough: e.g., feelings of specific need (longing, yearning) for the love object or of anger against objects which frustrate or threaten to frustrate these needs: also that these affects provide powerful incentives either to discharge instincts or, should discharge prove impossible, to control them. But most affects are neither simple nor isolated. Hence these approaches are not of much clinical utility. Actually the most useful clinical classifications of affect are into (1) *simple* and *compound* (or fused) affects and (2) *primary* and *secondary* affects.

Theoretically regarded a *simple affect* is a *specific emotional response to any given vicissitude of a particular instinct*. In practice it should be found in association with a fixed psychic situation having a standard unconscious content and it should be incapable of further reduction on analysis. Thus, for example, grief is often a simple affect, a direct reaction to the loss of a love-object. In course of development and as a result of the fusion of or interplay between different components of

instinct, simple affects inevitably tend to merge and form *compound or fused affects*. Once fused they are not ordinarily capable of reduction into their elements: or rather, stimulus of any one component tends to release the total affect. Compound affects are however capable of reduction under special circumstances: first, when mental disorder takes a mainly regressive form and earlier phases of development are re-activated, together with the simpler affects originally associated with them: and, second, during the psycho-analysis of any mental disorders in which a compound affect has been an important pathogenic factor. In many such instances it can be observed that the disturbing affect is reduced or disappears only after it has been broken up into elements each of which is associated with a characteristic nexus of unconscious phantasies.

Clinically, the most interesting example of a compound affect is the state of feeling that accompanies ambivalence to objects. But as ambivalence is usually unconscious it is difficult to study this early affective compound. More accessible to inspection are the compound affects of *jealousy* and *depression* which can be usefully compared with the simple affect of grief. While grief is an early reaction to the *absolute* loss of a libidinal object, jealousy is a later and more complex reaction to the *threatened* loss of that object. In typical instances it consists of anticipated grief, of anger and of fear; to which is added tension affect due to the unconscious homosexuality that is activated when a heterosexual striving is threatened with frustration. The grief is derived from partly-frustrated love, the anger from a threat to the self-preservative instincts (through the mechanisms of narcissism) and the fear from the combined tensions of object love, object-hate and narcissism.

Similarly with depressive reactions. Although these are very deep, so deep in fact that a small group of observers have been led into the error of assuming that they are primary affects aroused by hate and by threatened object-loss occurring as early as the first half of the first year, true depressive affect is invariably compound. The combination is however specific, being a fusion of grief due to actual loss of a love-object, of hurt due to loss of love, of grievance and anger against the love-object, of anxiety and of unconscious guilt feeling. The exaggerated inferiority and self-depreciation associated with depression arises from the fusion of these distinct affective elements.

Following the division of affects into tension and discharge affects respectively, it is tempting to say that primary affects include only responses to rise and fall of any given instinct excitation and that *secondary* affects are *reactive* in nature and occur when stimulation of one instinct leads to the counter charge of an antithetical instinct, as, for example, when an unconscious sexual drive that is under taboo con-

stitutes a threat to the ego and so sets up anxiety due to mobilisation of the instincts of self-preservation. The difficulty is that anxiety which, judged by these criteria, would certainly be regarded as a reactive or secondary affect, is undoubtedly a primary affect aroused by any threat to the narcissistic ego. On the other hand, it is not possible to be content with the division of affects into simple and compound, regarding all simple affects as primary and all compound affects as secondary. For not only is anxiety a primary affect and in addition a potentially reactive affect but it is apparently capable of further modification when owing to development of ego-institutions it is felt to be due to *internal* rather than to *external* danger. This modified form of primary anxiety is known as guilt and is the best example of a pure secondary or derived affect.

The distinction between primary and secondary affects is however easier to see when the affects in question are derived from separate instincts and can be shewn to exist in causal sequence. Thus, sexual tension can induce primary anxiety but it can also induce secondary hate which in turn can mobilise additional primary anxiety. Similarly primary anxiety can induce secondary hate: it can also mobilise sexual excitation and so cause primary tension affect. It is clear therefore that affects in many instances are not themselves the *expression* of the original instinct but are aroused *secondarily* by it. Again one affect may be represented by another of an apparently antithetical type, e.g. some feelings of hate are really inverted expressions of loving. But the most obvious, and clinically the most important illustration of the relation between primary and derived affect can be studied in the case of anxiety and guilt.

*Anxiety.*—Study of various affects especially those experienced in pathological states show that one of their commonest components or accompaniments, either direct or disguised, is anxiety. Anxiety is expressed directly in various degrees of apprehensiveness, up to and including panic, in various bodily disturbances (cardiovascular, respiratory, gastro-intestinal, secretory, muscular and cutaneous) and in every variety of anxiety-thinking. When these reactions or thoughts are attached to a particular object or objects, the state is described as fear. A *phobia* is a particular example of fear associated with an object or idea. It differs from ordinary fear in that the object is one which does not ordinarily justify fear. A phobia is a fixed form of *morbid* (unreal) *anxiety*.

The *nature and origin of anxiety* is still obscure. Generally speaking it is a reaction to danger and manifests itself variously in different species. The forms characteristic of man suggest that anxiety has a close connection with experiences of *birth*. The overwhelming excitations occurring during birth together with the onset of function or

of unassisted function in the cardiovascular system, respiratory and other organs, constitute the first traumatic experience. It is the prototype of all later anxiety manifestations both physical and mental. The anxieties experienced later are, however, merely *sample repetitions* of the original traumatic state. The function of these repetitions is protective: they force the individual to defend himself. Experiencing anxiety he is driven to take steps to avoid any stimulation that threatens to become overwhelming. A number of simple and conditioned reflexes and a number of simple or complicated behaviour patterns are set in action. These discharge the tension, as a rule, successfully. *Beyond a certain point, tension of any instinct threatens danger.* Loss of love, provoking love tensions, is felt to be a danger. Aggressive instincts are also felt to be dangerous, all the more so when they are of a nature which if expressed would injure a love interest and so give rise to secondary anxiety. It was once thought that the energy of frustrated sexual impulse was *converted* into anxiety. This is now regarded as an exceptional state of affairs. The frustrated instinct *arouses* anxiety.

*Guilt.* – When the frustration of any instinct is felt to be dangerous or gives rise to tension that is felt to be dangerous, *the natural result in either case is anxiety.* So long as the instinct remains active, anxiety may be expected to continue. Short of abolishing the impulse, the only recourse of the mental apparatus is to mobilise antithetical instincts frustration of which would create stronger anxieties than would the original frustration. To put the case another way: should an original impulse be incompatible with later impulses of a more powerful (antithetical) order, so that its gratification would now cause pain rather than pleasure, it is obvious that although the frustration may be painful in itself it will *prevent the new reaction of pain* arising from the frustration of the antithetical instincts. To this extent it will prevent the development of anxiety. If the gratification of a child's autoerotic impulses threatens loss of love from the parents, their frustration will prevent anxiety of loss of parental love. When, however, the more primitive impulse is powerful enough to resist frustration, both the primitive pleasure system and the new reality system are likely to evoke anxiety. *Neurotic and other mental symptoms are frequently called into existence because of this double threat.* A distinction must however be drawn between the anxieties. The threat of loss of love although exaggerated by the child is nevertheless to some extent realistic, but the sense of danger aroused by the frustration of the forbidden impulse is unrealistic to the extent that it is due to internal tension. The reaction produced is characterised as morbid anxiety and is a *sign of conflict between the pleasure-principle and the reality-principle.*

The newer reality systems are acquired in the course of cultural

development. Either consciously or unconsciously the child realises that the gratification of primitive wishes is attended by or threatens danger from without (disapproval, punishment). Of these external dangers an increasingly compelling one is the danger of loss of love. But in course of time it becomes obvious that primitive impulse is inhibited even in the absence of the external sources of inhibition (parents). This has been explained by the adsorption of the parental *imagos* in the child's ego. The fear of external loss of love is now constantly reinforced by an internal fear of loss of love; the 'self-self' fears to be disapproved of by the 'parent-self.' When it feels disapproved of a state of *guilt* arises. Just as the mental apparatus uses anxiety as a signalling system to warn of the approach of external danger so it makes use of guilt as a *signal* system to prevent the development of overwhelming inner danger. Guilt is a highly specialised form of anxiety which operates internally and does not depend on the presence or indeed the continued existence of actual threatening or disapproving objects. Guilt and anxiety overlap a good deal. Guilt tends to mobilise anxiety; it merges to some extent in anxiety and it exists along with anxiety. Anxiety in its turn tends to mobilise guilt. Individuals vary very much both in their *anxiety-readiness* and in their *guilt-readiness*. Both may appear in a disguised form, particularly when the source of anxiety or guilt is not conscious. Just as anger can be disguised by weakness and depression, so guilt affects can be manifested by *feelings of mental or physical inferiority*.

*Clinical Aspects of Affect.* – Affective states are important in the first place because they provide a powerful motive for adaptation or for illness (maladaptation) and secondly because they contribute characteristic features to any illness or inhibition that may ensue. Some mental abnormalities are labelled quite simply in accordance with the prevailing affect. The best examples are the so-called *anxiety states* and the *depressive states*. This system of nomenclature could have been extended. The affective responses in many obsessional neuroses are guilty as well as anxious. The obsessional neurosis is essentially a *guilt-neurosis*. Depressive states also exhibit guilt reactions but of a more malignant type. They might be called *guilt-psychoses*. Jealousy reactions are seen in their simplest form in many anxiety states but appear in a more drastic form in alcoholic and various paranoid conditions.

Rage responses are easy to observe in psychotic episodes. They also occur in some of the simpler hysterias, though they are not characteristic of the psycho-neuroses. They can be observed in certain anti-social conditions of a psychopathic type.

By way of contrast to these more disruptive affects, pleasure affects

of an excessive yet facile type are to be observed in the manias. They occur but also only occasionally in the hysterias. An obsessive form is found in various sexual compulsions (masturbation, fetishisms, and a number of perverse object relations). Careful anamnesis will usually uncover phases of painful or depressed affects associated with these euphoric states. It is more difficult to detect latent pleasure affects in conditions, which manifest themselves as predominantly painful. In some conversion hysterias and even in mildly painful organic disorders a certain degree of direct pleasure is occasionally extracted by the patient from his illness, but this occurs mainly in masochistic types.

It is obvious that much research is required on the affects produced by early fusions of instinct. Latterly Freud was inclined to distinguish between the instinctual reference in morbid anxiety and in guilt respectively. He regarded the guilt manifestations observed in the neuroses and psychoses as being due predominantly to conflict over unconscious aggressive (hate) drives. The view recently put forward in some quarters that unconscious phantasies have some inherently dynamic effect is due to a confusion between the ideational content of unconscious wishes and the instinctual energy with which they may be charged. *Affect is the true dynamic derivative of instinct.*

*Chapter IV*

## THE STRUCTURE OF THE MIND

The *locality* of mind is not a problem for the psychologist; or rather, it is the kind of problem he can with an easy conscience leave to the layman to thrash out with the neurologist. The psychologist, is, or should be, concerned primarily with the function of the mental apparatus. All he need say is that, in any given individual, psychic activities occur at a certain level of stimulation, that they occur in certain well-defined sequences which end in characteristic discharge phenomena, including conscious feelings, ideations and sensori-motor innervations. The nature of these stimulations has been described in the previous chapter on dynamics.

On the other hand, the *structure* of mind is a concept as essential to the psychologist and to psycho-pathology as concepts of atomic structure are to the physicist or chemist. Interestingly enough criticism of psychical concepts frequently emanates from natural scientists, who are apparently oblivious to the fact that to describe the unconscious elements in a complex or to outline the structure of a symptom is as legitimate as to employ ring-formulae to describe the compounds of organic chemistry. Even those psychologists who do not believe in the existence of unconscious layers of the mind, show a preference for structural analogies when they use terms such as 'field of consciousness,' 'rigid character' and the like. Nor is the psycho-analyst's interest in the concept of psychic structure a purely theoretical one. It has a number of practical (clinical) applications of which the following may be instanced: - (a) it can be used for purposes of clinical description and classification; as, for example, in the use of the term schizophrenia, a term to which however there is an obvious drawback, namely, that it is concerned with manifest or conscious signs of splitting, ignoring the fact that in its unconscious layers the normal ego is from an early stage of development already split: - (b) it is of service in establishing differential diagnosis; as when the structure of a depressive state is distinguished from the structure of a hysterical depression: - (c) it enables the physician to make an accurate prognosis and so recommend the most appropriate form of treatment; as when the respective depth of regression in different character disorders is established, or when the significance of an obsessional structure in any given case permits an accurate estimate of the importance of any suicidal ideas that may appear.



PSYCHIC SYSTEMS. As has been suggested, earlier concepts of psychic structure were essentially descriptive and expressed in terms of *consciousness* (awareness). Their practical value was greatly diminished by the fact that the observers were themselves convinced that mind and consciousness were co-terminous. Freud was able to demonstrate that mental products exist of which the subject is totally unaware, exist, that is to say, 'apart' from consciousness. Only then was it possible to maintain that consciousness is one of the functions of mind, or, in structural terms, that *it is a psychic system, a part of a total instrument or mental apparatus*.

Subdivision of the rest of the mind was then determined by the degree of accessibility of psychic products to the conscious system. Thus a great number of ideas or memories can, at any given moment, be unconscious in the descriptive sense. The individual is unaware of them. Yet they are accessible to consciousness; they can be recalled with a varying degree of psychic effort. The system in which these accessible ideas and memories are stored is called the *pre-conscious system*. In order to emphasise its structural as distinct from its functional aspects, it is usually designated the *pcs*. Although superficial in the sense that it lies nearest to *consciousness* (*cs*) and therefore to the external world, it is an extensive system with rich and diverse content. It stretches, actually, as far as memory can reach. It is not, however, a purely passive receptive system or repository. In accordance with the charge of immediate interest attached to its ideational content, preconscious ideas have, as it were, *right of entry* into consciousness. They can exercise the *power of presentation*. Such presentations are used to further adaptation to reality, or to promote the aims of phantasy-thinking as e.g. in day-dreaming. A large part of intellectual and imaginative work is carried out by this system.

There are, however, still other mental products which are unconscious not only in the descriptive but also in a dynamic sense. No ordinary effort will render this content accessible to consciousness: on the contrary powerful forces strive to prevent its becoming conscious and equally powerful forces are required to overcome this opposition. This is the true *unconscious system* (*ucs*) and was originally conceived of as lying at the instinctual end of the mental apparatus. Its content is also rich but archaic. Some of it relates to previous conscious experience, particularly experiences of a traumatic or profoundly emotional nature occurring in early childhood; but there is no longer any free communication between these experiences and consciousness. Their entry or indeed the entry of any of their derivatives into the pre-conscious system (where they would automatically become capable of re-entering consciousness) is opposed by a barrier which is itself unconscious (see *repression*). On the other hand a great deal of unconscious

content has never been conscious. It is extremely primitive in nature consisting for the most part of phantasies derived from early instinctual frustrations but not, as is frequently imagined by uninstructed critics of psycho-analysis, either exclusively anti-social or exclusively sexual. On the contrary like the repression barrier itself, large tracts of the ego, particularly those that are concerned with the *restraint* of primitive instinct, are also unconscious. Also the earliest forms of love-interest may be as effectively barred from consciousness as the earliest strivings of hate. Being dissociated from consciousness, the unconscious system has no direct contact with reality and is governed by laws and mechanisms which appear alien to the more logical processes that take place in the (pre) conscious system. To signalise this difference the processes governing the activities of the unconscious system are described as *primary processes*, e.g., the mechanisms of condensation and displacement (see *Mental Mechanisms*, also *Dreams*). The pre-conscious system on the other hand is regulated by *secondary processes* which are largely responsible for intellectual operations. Being very loosely organised and constantly reinforced by direct charges of often anti-thetical instincts, unconscious content appears to be illogical, inconsistent and self-contradictory. The unconscious system is also timeless. Its mechanisms are most easily studied during the analysis of *dreams*. *They are also responsible for some of the characteristic features of neurotic and psychotic symptoms*; for example, the reaction-formations of the neurotic and the delusions of the paranoiac.

Some difficulty in grasping the structural aspects of mind is due to the fact that although Freud's clinical work was continuously concerned with the function of the *ucs system*, he made only two systematic attempts to outline the mental apparatus in structural terms. The first was presented in the theoretical part of his treatise on *Dreams*. After an interval of twenty-three years Freud published his second outline. This was necessitated by his further researches on the nature of ego-instincts. These led him to revise the relations between the concepts of 'instinctual energy', the 'unconscious', 'repression', and the 'unconscious components of the ego'. It should be understood, however, that this second outline does not supersede the first, which in many respects is still essential to the understanding of mental processes (see *dreams*, *hallucination* and *projection*). As, however, a new terminology was introduced some confusion is bound to arise in the mind of the student and can best be eliminated by describing the outlines separately. In any case it should be remembered that in metapsychology three distinct approaches, viz., dynamic, topographic and economic are necessary to the understanding of psychic activities and that each of these approaches can and often must be described in a number of ways.

*The Mental Apparatus.* Freud's earlier outline of his theory of mind did not claim to describe psychic structure in a way that was capable of satisfactory diagrammatic representation. At best psycho-analytical diagrams are merely aids to presentation; it would be unreasonable to expect otherwise. Nevertheless it dealt with *basic concepts of mental structure* and, following the physiological pattern of the reflex-arc, described the *sequence* of mental events in a way which suggested the functioning of a *central mental apparatus*. Perhaps the best example of a basic concept is that of the *memory-trace*. Taking a serial view of psychic activities it is easy to imagine the mental apparatus as having a 'receiving' (afferent) and a 'discharging' (efferent) end, or, to put it rather too simply, a sensory and a motor end. Stimulations coming both from without and from within could then be described as impinging on the sensory end of the apparatus. At this point cognisance is taken of them by consciousness (cs.). Now, clearly, some psychic record of these stimulations exists and, equally clearly, the record cannot be imagined as existing in the cs. system, otherwise the perceptual function of the system would be hopelessly prejudiced. It would be perpetually swamped with memories. Hence the concept of the *memory-trace*. Provided the stimuli are strong enough they pass through consciousness and produce permanent alterations in the (originally) unorganised psyche. The memory-trace is as it were burnt in. Consciousness does not itself retain memory-traces. It merely (a) takes cognisance of (perceives) stimulations coming from without (in this sense the external world includes the subject's own body) (b) is aware of inner stimuli, i.e., ideations and affects produced by instinctual forces.

Having laid down this postulate, for it is essentially a postulate, Freud was able to make rapid progress with other structural concepts. Thus, the association or superposition of memory-traces arising from repetition of similar experiences leads gradually to the *organisation* of mental *images*. In more primitive phases these imaginal forms are mostly based on *visual* experiences although early olfactory and tactile stimuli are also important; but in course of time *auditory* stimuli play an increasingly extensive part in ideational development. This is greatly reinforced as the power of speech develops. The re-activation of these memory-traces leading to re-entry of images and ideations into consciousness (memory) is a dynamic process. Images associated with any given situation are reactivated by charges of instinct energy. These activating charges or investments have been given the outlandish name *cathexis*.

All these early formations are influenced by a tendency of the mental apparatus towards *synthesis*; memory-traces are organised into images and, in accordance with the instinct or experience involved, are later developed into systems of images. At this point we can link theory with

clinical observation. As we have seen, from the time when it is possible to apply the techniques of psycho-analysis, the mind is found to be already divided into three great systems, the unconscious, the pre-conscious and what we can now call *perceptual consciousness* (pcpt-cs). Retracing our steps from the clinical to the theoretical we can regard the unconscious and pre-conscious systems as built up from lesser and more scattered systems, which can be traced back to the formation of primitive memory-traces. Of the two systems the pre-conscious is immeasurably the more synthesised.

The next step is to link these basic concepts with the concept of the *ego*. *Theoretically regarded, the ego is simply the total organisation of memory-traces*. Used in this very general sense the term is of little clinical significance. By the time we can apply psycho-analytical methods to inspect this total ego we find that it has already been divided into different ego-systems. And since the child has at first difficulty in distinguishing between the self and what the observer knows to be the external world, the first and most elementary division of the total ego is into two main departments – a department concerned with the self and a department concerned with the external world or, more accurately, the *instinctual objects* that exist in the outer world. An external instinctual object is that which is necessary for the gratification of externally directed instincts; e.g. in the case of hunger excitations, food (breast-mother). Detailed examination of the psychic representation of an object shews that it has an elaborate structure. It is a nexus of images and associated affects built up in accordance with experiences of instinct gratification or frustration. This is called an *imago*. Its function is primarily to promote realistic relations with objects in the external world, although of course object *imagos* are activated also in dreaming and day-dreaming.

A common source of difficulty in grasping mental relations is to conceive psychic objects as something existing outside the mind, something, as it were, of flesh and blood. *The object imago exists in the mind*; it is an organised part of the mental apparatus and has both unconscious and pre-conscious aspects. This arrangement promotes continuity of psychic function. Once *imagos* are built up, object relationships no longer require to be reactivated by the actual presence of the real object. Contrariwise an appearance of easy contact with actual objects is often misleading. Closer examination may shew that the individual's object relationships are of the most tenuous variety. As a rule shallow object relations tend to have pathological consequences.

The energies of the mind are of necessity distributed between these two systems. When impulses towards an object cannot be gratified either from extrinsic causes or because the urge mobilises anxiety or guilt or both, the mind tends to withdraw the energy of the instinct

from that object and, if substitute objects cannot be found, to put it at the disposal of some aspect of the self, or, more accurately, attach it to the psychic presentations of some aspect of the self. Libido withdrawn from the object to self inflates self-valuation, and in excess can produce any type of over-estimation from cock-suredness to megalomania or any type of under-estimation from hypersensitiveness to the most extensive inhibition of social contact (see also *narcissism*). Withdrawal of aggressive energies on to the self can produce any reaction from slight shyness, inferiority and timidity to alienation, suicidal depression or catatonia; or, should the increased aggression be again reflected towards objects, to any reaction from suspicion and aggressiveness to delusions of reference and violent assault.

From both diagnostic and prognostic points of view it is essential to assess *the balance of interest as between the self* (the ego in a narrower sense than that so far used) *and its objects*. Some freedom to attach love and hate impulses to objects is essential to health, in some respects more important than the actual gratification of adult impulses. Extensive withdrawal of interest from real external objects is a clinical danger signal. Excessive reduction in object contacts owing to extrinsic causes is also a precipitating factor in breakdown. This is observed in an acute form in the reactions to solitary confinement in prison, or in a less striking degree in prolonged segregation from objects of the opposite sex, a state of affairs that arises more frequently under conditions of combatant service. These interruptions are however less significant than the withdrawal of object libido within the mind. Prolonged impoverishment of object-relations following withdrawal of instinctual cathexis from object-imagos, predisposes to psychotic breakdown. If however, despite an apparent diminution of external contacts or gratifications, internal interest in objects (i.e. cathexis of the imago) is retained, we need not anticipate more than a neurotic breakdown. *Diagnostic skill depends almost exclusively on the capacity to make accurate assessments of ego-object relations*. In some cases the physician finds that his criteria are intuitive rather than systematic in the clinical sense.

As has been indicated, Freud's later outline of mental structure was necessitated by deeper researches into the nature of what till then had been described as ego-instincts. The drawback of his earlier description of an unconscious system (*ucs*) was that it did not indicate very clearly the relation of dynamic forces (instincts) to the ego. Increasing realisation that large tracts of the ego and of its component parts are unconscious, not only in the descriptive sense but in the sense of being permanently shut off from consciousness, called for more precise definition of the relation of this unconscious ego, on the one hand to

the mental products controlled by the repression-barrier and on the other hand to the unconscious instinctual forces that activate all mental function. In his earlier description it had been convenient to combine dynamic and structural concepts of 'the unconscious'. One could conceive of this system as lying nearest to the sources of instinctual excitation and therefore being constantly re-charged by powerful psychic energies. But the more deeply Freud carried his dissection of ego-structure the more necessary it became to distinguish between structural and dynamic aspects of what had previously been subsumed under the term *ucs*. In trying to present this later outline therefore it is convenient to follow the direction of Freud's researches and consider first the ego-differentiations that led to the new nomenclature.

**EGO-DIFFERENTIATIONS.** It is not surprising to find that some of the most important advances in psycho-analysis were already foreshadowed in the earlier concepts and technical terms used by Freud. In describing the operation of the repression-barrier as observed during the analysis of dreams Freud had found himself compelled to postulate as a function of the unconscious mind an activity called the *censorship*. (See *Dreams*). This censorship was regarded as responsible for setting the mechanisms of repression in operation. For many years the censorship was erroneously referred to in unofficial accounts of psycho-analysis as the 'censor'. Although the error was due to the common habit of personifying psychic functions, it was nearer to the truth than the writers realised. For in course of time Freud saw that the unconscious scrutinising tendencies of the mind constituted a specialised function of the ego or, more accurately, the function of a specialised part or institution of the ego. This differentiation of ego-structure proved to be of inestimable clinical value, and, incidentally it is a distinction that can be easily confirmed by ordinary introspection.

*The Super-Ego.* The simplest experience of conscious 'self-questioning' shews that one part of the mind exercises scrutiny over another part. Experience of 'self-control' shews further that this scrutinising part issues judgements which the other (executive) part is prepared to accept. The scrutiny and the control are not difficult to detect, but, unless in cases of obvious 'moral' perplexity, the process of judgement is obscured by the common belief that the factor responsible for 'action' in other words the 'motive' is a conscious, voluntary and allegedly rational 'factor'. To use modern psycho-analytical terminology, the scrutinising and criticising part observed by introspection is a *conscious facet of the super-ego* which pronounces judgement on a *conscious facet of the real ego* which in turn is responsible for carrying it out. It is easy to discover that the bone of contention between the two conscious systems is some

conscious derivative of instinct (impulse, thought, wish, feeling, projected utterance or action) which is disapproved of by the conscious facet of the super-ego. The disapproval is evidence of a state of tension between the two systems one of which threatens the other with loss of love, commonly described as loss of self-esteem. The feeling tone of this tension is commonly referred to as *guilt* and is attributed to the action of *conscience*, in this case *conscious conscience*. That conscience is a function of a specialised part of the ego can be inferred from the usages of speech, as when an individual referring to some ethical issue, maintains that it lies between *him* and *his* conscience. Many psychologists think – and this is also the popular view – that such guilt-states are transient, the result of temporary splittings of the conscious personality. This is only descriptively true. Naturally when conscious impulses and interests are concentrated on non-controversial or non-conflicting (i.e. innocent) aims, the divisions of the conscious ego are not apparent. They merge in a common purpose. The surface of the mind appears unbroken and there is no sign of the existence of conscious conscience. Nevertheless the psycho-analytic view is that a much more permanent cleavage into ego and super-ego exists below the surface and that it reaches down to deep unconscious psychic levels. In other words *there is a deep unconscious conscience of which conscious conscience is merely a superficial facet*.

Concerning the earliest phases of development of the super-ego and the age at which they first occur, there are naturally some differences of opinion. Nevertheless there is general agreement that *the most important period, during which the organisation, outline and effective function of the (unconscious) super-ego are established, is during what is called the Oedipus stage of infantile genital development*. This extends roughly between the ages of three to five years. This was expressed by Freud in the aphorism that the super-ego is the heir of the Oedipus complex, implying thereby that it is finally formed when the Oedipus situation together with its derivatives is abandoned. And certainly the 'behaviour' of the super-ego, in particular its reaction to infantile sexual and aggressive impulses, does bear a close resemblance to the attitudes of parents, whether these attitudes are explicit or merely inferred (and in the process of inference exaggerated) by the child both consciously and unconsciously.

No sooner was this formulation accepted than the theoretical and practical interests of psycho-analysts were directed (as had so often been the case) to filling in gaps, in this case the gap between the later Oedipus phase and the earliest differentiations of ego-structure which had previously been indicated in a very sketchy manner, or to be strictly accurate, guessed at by means of hypothetical reconstruction. This naturally gave rise to confusion; for it is difficult if not impossible

to link hypothetical concepts of early development with actual clinical discoveries concerning later development. The usual result is that a hypothetical reconstruction tends to be regarded as a clinical fact; whereas the two approaches to psychic phenomena are entirely distinct.

Anyhow, two schools of thought began to develop. The first, which incidentally is both numerically and scientifically the stronger, accepts the view that the classical Oedipus phase represents the period during which effective super-ego formation occurs. It is content to look for evidence of more primitive or transitional forms performing controlling functions similar to those of the super-ego but in a much less organised, haphazard and sporadic fashion. This approach is adequately expressed in the phrase 'forerunners of the super-ego'. By way of contrast a small group was not content simply to look for primitive forerunners of the super-ego but headed in the opposite direction, viz., to establish that already in the first half of the first year, that is to say, during the suckling period, a true Oedipus situation develops; not just an embryonic and unorganised form of Oedipus situation based on the *oral* relations between the infant and its mother, but an Oedipus situation with important *genital* elements. This, it is held, is activated by the infant's early struggles with oral sadism and leads to the formation of a true super-ego already before the sixth month. This archaic form of super-ego, it is maintained, exercises a decisive and permanent influence on all subsequent development. This view has not been accepted in psycho-analytical circles. It is in fact merely a speculation or at best a hypothetical reconstruction. Both biologically and anthropologically regarded and also according to the sheer weight of verifiable clinical evidence, *the classical infantile genital Oedipus phase represents a nodal point in all development*. Its passing is recorded in the development of a major mental institution. The fact is that the child makes swift steps towards adult development and reaches an almost adult genital level between the third and fifth year. This precocious drive is halted and the attempt to build up an adult system of sexual gratification shattered. The memory of this by no means inconsiderable feat, and of its subsequent miscarriage is perpetuated in the activities of the super-ego.

*Structure of the super-ego.* Compared with the minute structural differentiations of anatomy, or with the detailed functional descriptions of physiology, the division of the mind into ego and super-ego appears rather crude; nevertheless the constituent parts of the super-ego can be classified in a number of ways. The simplest has been indicated above. During the pre-genital phases of infancy the child has passed through instinctual crises leading to the abandonment in turn of oral,



excretory and other forms of infantile sexual interest. Now the more completely the instinct is abandoned, the more likely it is that an effective control system has been set up in the mind. Theoretically any system that instigates the inhibition of instinct performs in however rudimentary a manner, a super-ego function. The earlier the function, the more it is concerned with primitive instinct. It is possible therefore to subdivide the super-ego into *layers representing historical phases of the infantile struggle to master primitive forms of instinct*. As has been indicated the main groups of *infantile* instinct are concerned with love and aggressivity respectively. These vary in quality, intensity and distribution in the different phases of early childhood. And there are numerous combinations (fusions) of infantile sexuality and aggressiveness. Since the majority of these impulses are concerned with hate of parental objects who are both loved and feared they cannot and may not be gratified, and tend to lead to the abandonment of that particular object. It is reasonable to assume that, although in early infancy it is not very well organised, a kind of super-ego reaction develops for each phase. Although it cannot be regarded as a psychic institution, it is safe to say that it represents a *nucleus* of a super-ego system. Thus owing to the early primacy of *oral* love and hate we can say that one of the earliest nuclei of super-ego formation is an *oral nucleus*. This means that ego-phantasies of oral sadism (devouring, biting the mother or breast) arouse an inner conviction that a talion oral punishment is threatened (being devoured by a 'wild object'). And we know from study of depressive cases that the appropriate affect induced by this opposition is one of depression. In the case of later phases of love and hate, there is less need for speculation and hypothetical reconstruction. Clinically one can observe that excretory (*anal, urethral*) interests and their corresponding phantasies are controlled by what Ferenczi called 'sphincter-morality'. Study of normal character shews many reactions derived from this phase. These can now be described as a result of the activity of a substantial *nucleus* of the super-ego, the *anal super-ego*. Pathological formations dating from this period can be easily detected during the analysis of cases of obsessional neuroses.

At this point we reach the final genital period of development the abandonment of which leads to the formation of the true *genital super-ego*. This not only mobilises in the ego genital guilt and anxiety of genital punishment (mutilation, castration) but serves to control those complicated psychic derivatives of the incest (Oedipus) situation, jealousy, rivalry, hostility, etc. By so doing it establishes its undisputed unconscious authority over all ethical and moral issues. Excess of incestuous impulse or excess of super-ego activity at this stage lays the foundation of hysterical formations (conversions and phobias).

In general the deeper the cleavage of the mind into ego and super-ego,

the more the super-ego is concerned with primitive derivatives and the less it is capable of being spontaneously affected by reality influences. For example, when deep guilt erupts, as in the depressive psychoses, we find that the self-accusations are not justified in reality. They are delusional. This expands our view of the nature of depressions. Affectively they can be regarded as guilt psychoses but structurally they represent an extreme hypertrophy of the deeper nuclei of the super-ego. In such cases the super-ego is over-sensitive in detecting guilts that have little or no relation to actual behaviour and issues judgements of fantastic severity, which the ego is apparently compelled to accept (as when the outcome is suicide).

The close connection between instinct tensions and symptomatic reactions suggests another way of subdividing both ego and super-ego systems, namely by reference to *the characteristic mechanisms set in action*. Some of these are typically *ego reactions*. Forgetting is a typical example of an ego-reaction. Passivity, inertia, inaction are also ego responses. Like denial they may be considered as forms of flight. There is nothing essentially moral about them. *Super-ego reactions* have a very definite moral stamp, even if it be a primitive morality. A direct manifestation of this activity is to be observed in the *moral rumination* of some obsessional neurotics. The nature of these moral systems can be deduced from the responses they evoke in the ego. The more primitive or the more sadistic the super-ego the more it demands talion *punishment* of a condign nature; as, for example, in suicide. In more developed types the punishment is more localised (e.g. castration for incest wishes) and (or) attempts are made to *expiate* or make *restitution* for the unconscious crime; e.g., phantasies of giving birth as an expiation of death wishes. The sadism of the hysteric super-ego localises the punishment to (substitutes for) the genital organs. In obsessional cases two phases can commonly be observed. One represents the unconscious crime i.e. the unconscious phantasy; the other annuls or counteracts or makes good the alleged delinquency. An 'evil' gesture or ritual is carried out and either followed by the opposite gesture or by a 'good' repetition of the same gesture. Compulsive philanthropists, though not neurotic, have a similar type of super ego. They make restitution by giving. Compulsive gamblers and toppers belong to a compromise group. They punish themselves and make restitution by wasting their own substance. *Reverse action* of the super-ego is seen in paranoid types. Some paranoid patients show violent disapproval of evil, but, unlike persons with a guilty conscience, the evil is held to exist in the external world (imagined enemies who are alleged to attack them). Inner psychotic guilt is reversed. In the frenzied quest for a state of innocence, evil is first projected on to the outside, then detected and finally punished. The super-ego of the delinquent works in a somewhat similar way.

Perhaps the most interesting subdivision of super-ego structure, certainly the one that gives the clearest idea of its origin, is that made in terms of *relations to the early objects of impulses*. The supervising and criticising nature of all conscience activities suggests that the super-ego repeats within the mind patterns of parental control already experienced in relation to family figures. But it is not due simply to an ordinary identification with these objects. In the first place the ego-differentiation is extremely rigid and under ordinary conditions permanent. The infant having been compelled to abandon its incestuous aims towards its parents withdraws the energies of these instincts, sets up within the ego permanent parental institutions and invests them with the withdrawn energies. It is as if a part of the mind became a parental part, as if the parents had been psychically 'swallowed' (see *introjection* mechanisms). Secondly, the attitude of these parental institutions in the mind is more primitive e.g., cruel than those of most real parents. This is due partly to the fact that the infant projects its own hostilities on to the parents, and consequently 'swallows' a hostile object, and partly to the sadistic energies that operate through the super-ego. Sometimes the attitude of the super-ego corresponds less to the image of a parent than to the imaginary attributes (savage or otherwise) of a parental organ (mother's breast, father's penis). Proceeding on these lines, super-ego systems can be divided into mother types and father types. Since there is a frequent alternation between conflicts induced by the mother and those induced by the father these divisions overlap considerably. But it is to be noted that the tendency in super-ego formation is to single out the thwarting aspects of the parents, hence the super-ego is commonly modelled on the pattern of the parent of the same sex. One of the worst psychic situations is where the child unconsciously feels itself disapproved of by or hostile to both these parts of the super-ego. Division of super-ego in terms of objects is extremely important in the investigation and treatment of *abnormalities of character*. Persons who are unable to fall ill of a psycho-neurosis may inflict a good deal of suffering on themselves and others by behaving in their social and sexual relations in accordance with the dictates of an archaic father or mother super-ego.

Important as are the structural aspects of the ego, it is scarcely necessary to add that *these differentiations would be of little clinical significance were it not for the fact that they help to master charges of frustrated instinct*. The main function of ego-differentiation is to assist in controlling the unsatisfied tensions of primitive love and primitive hate of objects. Having failed to master them by more primitive methods (see projection and other primary mechanisms) the ego succeeds in absorbing frustrated excitations at the cost of 'adsorbing' their objects. But of course the energies used by the super-ego are the child's own

mental energies. These, too, are split up, distributed between ego and super-ego systems and played off against each other. The channels by which energy reaches the super-ego are both direct and indirect. So devious indeed are some of them that they cannot be intelligibly described in any summarised presentation. The more direct forms can be easily identified by studying the 'behaviour' of the super-ego. Its severity and tendency to torture or persecute the ego are clearly derived from the sadistic groups of instincts, reinforced by the hatred that is sometimes freed when incestuous libido is withdrawn. Its curiosity, interference and probing, its suspicion of unconscious sexual derivatives, can be traced to the child's original hostile curiosity as to the sexual functions of the parents. On the other hand, as well as attracting hate to itself via the ego, the super-ego stimulates a good deal of primitive narcissism. It is not hard to prove that the ego has a great fear of loss of love from the super-ego, and is greatly enhanced when its own ideals approximate to the standards laid down by the super-ego.

In some instances the interplay between the hostile aspects of super-ego functions and the narcissistic need of the ego for internal as well as external love is responsible for a form of unconscious moral rumination so crippling that it was given a special designation by Freud, namely *moral masochism*. But like all disordered mental products this condition is motivated by a certain amount of unconscious cunning. For although the normal function of the super-ego is to *prevent* the activation of incestuous impulse, this exaggerated absorption with internal conflict constitutes a 'psychic re-enactment' of what was previously a struggle between incest wishes and external frustration. The concept of moral masochism is admittedly difficult to grasp but it has considerable clinical value. In such cases, unconscious conflict is more than a conflict over incest; its exaggeration and constant repetition together with the inhibitions to which it gives rise constitute an intra-psychic continuation of the Oedipus situation.

**THE CONCEPT OF THE ID.** Having outlined the divisions of the total ego, we are now in a position to consider the third main psychic system to which Freud gave the name of the *Id*. As has been pointed out the earlier concept of an unconscious system (*ucs*) had to be approached *simultaneously* from two angles, the dynamic and the topographic or structural. Once the unconscious ego had been described in more detail, it became necessary to relegate the instinctual forces to a system of their own. After all, every variety of mental activity, whether normal or abnormal, is activated by instinctual forces. But instinct is a dynamic concept and cannot be represented in structural terms. The problem was therefore to conceive of an 'unsystematised psychic system' whose relations to organised mental structure could be well enough defined

to make psychic function comprehensible. Hence the concept of the *Id*. This can be described only by combining two approaches. On the one hand it can be conceived of as a reservoir of instinct tendencies. Using the older linear (or serial) concept of the mental apparatus we can place it at the instinctual end of this apparatus, at the border between the somatic and the psychic. On the other hand we can adopt the (potentially structural) concept of an *unorganised* psyche, at the margins of which memory-traces are deposited and the foundations of an organised total ego are laid. In this 'next to structural' sense the *Id* is not only unorganised but entirely impersonal. There is no ego in it. It is, as it were, a wishing well on the surrounding walls of which the story of gratification and frustration is recorded.

As in the case of instincts, the *Id* can be recognised only by those derivatives that pass through and influence the other mental systems. Ideational presentations derived from *Id* excitation have to pass through both unconscious and pre-conscious systems to reach consciousness. Affective derivatives by-pass ideational channels and spring directly into experience. It is obvious therefore that the *Id*, unlike the ego, is not a clinical concept; it is a concept necessary to the understanding of clinical data. The *Id* supplies both ego and super-ego with the energies with which they operate. It is permanently unconscious. The super-ego is for the largest part unconscious with, however, some conscious facets. The ego has also a deep unconscious part, but a relatively larger proportion of it is preconscious, accessible to consciousness and *via* consciousness, to the influences of external reality. The important point is that the super-ego is much more in touch with and sensitive to the *Id* than the ego. This accounts for the apparently mystifying nature of symptom formations. The conscious ego is unaware of the *Id* impulses which stimulate the unconscious super-ego to activity. It is also unaware that super-ego activity has compelled the unconscious ego to make adaptations. This explains why patients are unable to understand the cause of their illness and why they tend to accept more superficial and apparently more rational explanations of it.

Concerning the relation of the *Id* to phantasies or emotional experiences that are or have been rendered dynamically unconscious (repressed): it can be argued that if the *Id* is unorganised, it is not legitimate to include within its boundaries any ideational derivatives of instinct. Nevertheless repressed derivatives share with the *Id* the characteristic of being dynamically unconscious. And since much of the repressed has never been conscious, it is convenient to think of it as situated on the margins of the *Id*. It is clear however that only the instinctual elements of the repressed can strictly speaking be regarded as belonging to the *Id*. Ideational derivatives belong to ego-organisation.

NUCLEAR THEORY OF THE EGO. Whenever difficulties are encountered in grasping the theory of mind, it is a useful practice to think of the particular problem from a developmental angle. Admittedly many difficulties in understanding early ego-structure are due partly to inadequacies in presentation, and partly to lack of direct evidence. On the other hand many of them are due to subjective bias in thinking. When we try to imagine the form of the ego we tend to *think* of an *entity*, an organised whole. Starting from the surface and thinking 'downwards', we are then inclined to carry with us our preconception of a total ego, and so fall into the error of imagining that the foundations of the ego are as elaborate as its superstructure. In former times it was sufficient to postulate a primitive and undifferentiated psyche that gradually develops a recognisable outline and a number of component parts. When it became obvious that these component parts developed earlier than had previously been imagined, many observers swung in the opposite direction and began to postulate a highly organised ego in the first year of life. These mistakes can be avoided and most of the difficulties in grasping the development of the ego and its relations to other mental systems can be overcome by thinking less of unified structure and more of scattered deposits which are later organised into ego-systems. This *nuclear theory of ego formation* was developed by the author from Freud's original idea that memory-traces are first of all laid down in separate psychic systems or focal points. It is easy to imagine that the periphery of the Id is to some extent modified by experiences of gratification and frustration; also that these experiences can be classified in terms of the main instincts or component instincts concerned. If it is permissible to speak of an oral primacy of instinct and of an ego that is predominantly interested in oral gratification, or contrariwise in the anxieties that follow oral frustration, it is equally legitimate and much more plausible to speak of an *oral nucleus* of the ego. Similarly with the other primacies and components of infantile instinct. Thus experiences of anal gratification and frustration, of the anal hostility towards frustrating objects, of the conflicts that follow the gradual institution of an internal controlling agency which inhibits both the libidinal impulses and the reactions of hostility, together with the affects that are appropriate to each stage of the process result in the development of a nexus of unconscious anal-sadistic phantasies. These experiences, affects and phantasies make up the *anal-ego-nucleus*. In principle *any organised system of memory-traces and (later) ideations that contributes in the first instance to the gratification of a specific instinct or component instinct, and later to the control of the same instinct constitutes an ego nucleus*. The function of this nucleus like the function of the total ego is primarily to reduce tension in the mental apparatus, either by promoting discharge of libidinal and aggressive excitations

or by reducing their intensity.

Needless to say the number of ego-nuclei is not limited by the *primacies* of instinct. No doubt oral, excretory and finally genital formations are the most elaborate and most important. Nevertheless throughout these various primacies all the other libidinal components pass through phases of activity, which die down, either when the instinct is abandoned, as in the case of actual breast (sucking) impulses, or when its derivatives are controlled. Each of these isolated phases of development are recorded in appropriate nuclei. Genital interests for example, exist from birth, and only reach their infantile climax in the fifth year, but throughout this period a continuous record of genital experience is laid down. It is natural to suppose that in the sense of organisation, the earliest nuclei are the most loosely developed and the most widely scattered. No doubt there is at first a certain amount of confusion and overlapping, but true synthesis of the various nuclei formations cannot reasonably be expected until the boundaries of the total ego are clearly defined, and that does not happen as a rule until the later stage of anal primacy is reached i.e. during the second half of the second year.

Apart from resolving difficulties as to the relation of the Id to early ego-formations, the nuclear theory has many clinical advantages. It provides a satisfying explanation of the phenomena of dissociation and expands the concept of regression, particularly those regressions of the ego in which a more primitive but yet organised system occupies the approaches to consciousness. Finally it allows of a more systematic classification of mental disorders and of a more precise and detailed formulation of the specific etiological factors operative in each type of disorder. Although the nuclear theory of the ego has so far been presented only in outline, and has not yet been generally accepted, it is likely that future investigations of the early stages of ego-formation will necessitate its adoption. Without in any way departing from the principle of psychic continuity it maintains that the natural order of psychic development is from the simple to the complex.

*Chapter V*

## THE ECONOMICS OF MIND

If our knowledge of mind were confined to its dynamic and structural aspects, we would be entitled to assume that the primary function of the ego is to secure the gratification of primary instincts and its secondary function to scale down the demands of instinct to the point where they do not conflict violently or disadvantageously with the conditions imposed by environment. But we would still be in the dark as to the means by which the ego succeeds in carrying out these functions. When we say, for example, that the super-ego instigates the ego to inhibit instinct, this statement tells us nothing of the process of inhibition. The investigation of ways and means of solving the problems of adaptation constitutes the *economic approach* to mental activity. It is indeed the only approach which gives us a clear idea of the *total function* of mind; namely, to reduce the sum of mental excitation to an optimum level, either by securing gratification of instinct or by maintaining an effective balance between the claims of conflicting instincts.

The situation can be briefly stated as follows : — the greater part of infantile instinctual energy, both libidinal and aggressive, and a considerable amount of adult instinct is subject to frustration. The ensuing tensions are not only responsible for varying degrees of mental discomfort ('pain') but are potentially dangerous in that they may give rise to or precipitate mental breakdown or serious forms of mal-adapted conduct. Faced with the task of mastering frustrated energies, the mental apparatus is compelled either to find substitute gratifications; or to distribute the energies through the various (topographic) systems of the mind in such a way that the excitation is held in suspense by an opposition of forces (as when aggressive forces are distributed between the ego and the super-ego); or again, by inhibiting the frustrated energies as near as possible to source, or at any rate, before they can approach the motor (discharge) end of the apparatus. This economy of mental function is achieved by means of a number of *unconscious mental mechanisms*.

The term mechanism has been chosen because it lends itself to both dynamic and structural interpretation; it is preferable to terms such as 'pattern' which are not only exclusively structural but also static. Like other basic concepts in psycho-analysis the concept of a mental mechanism is incapable of further reduction. Speculations as to the origin of psychic mechanisms are interesting in their way but so far have not proved of theoretical value. We can say that the unconscious



mechanisms we find already in operation by the time it is possible to analyse a child must have existed from birth in the form of 'tendencies'. And since the mind at birth is almost wholly (though no doubt not entirely) *Id*, we must conclude that these tendencies like all products of racial experience must have been transmitted through the *Id*. But to seek to explain a 'mechanism' in terms of a 'tendency' is largely an exercise in verbal play.

To understand the function of psychic mechanisms, it is necessary to use three working concepts, first, of quantities of psychic energy, second, of ego institutions through which these energies are refracted, and, third, of ego-barriers that prevent their passing either into the conscious system or into motility (behaviour) or both. Of psychic energy it is only necessary in this connection to say that it *charges* or *invests* or, to use the more technical term, *cathects* ideational *presentations* or systems of presentation and gives rise to affects appropriate to the aim of the instinct concerned. In the case of instinctual aims that do not cause conflict this cathexis is sufficient to carry the impulse to motility, and give it effect. Where conflict is aroused it is the task of mental mechanisms to abolish, reduce, break into smaller quantities, distribute and finally inhibit the discharge of this cathexis at any point between excitation and motility. As far as affect is concerned it is sufficient if the mechanism prevents its development.

These functional aspects must of course be correlated with the structural aspects of mind. As has been indicated earlier the unconscious system is regulated by *primary processes*, the preconscious system by *secondary processes*. The aim of the former is mainly to promote *discharge* of the free psychic energies that activate the unconscious system. The secondary processes governing the preconscious have more complicated aims. They too must promote discharge of instinct, but the discharge must be consonant with the reality needs and capacities of the ego. This can only be done provided the free energies of the unconscious system (or *Id*, to use Freud's later terminology) are to a considerable extent *bound*. This binding of psychic energy is one of the main tasks of the preconscious system. Once it has been accomplished, the preconscious system is able to use *samples* of energy in the process of thinking and so prevent the automatic discharge of unmodified instincts in the form of behaviour. Thinking is essentially a check-system, delaying gratification and so permitting more effective adaptation to environmental conditions and to ego-codes of behaviour. From this point of view unconscious mental mechanisms promote the total function of the psyche, by affording it breathing space during which the task of binding is carried out. Expressing this in structural terms we may say that *the most important aspect of mental activity concerns the relations of the unconscious to the preconscious system,*

*relations which are governed by unconscious mechanisms.* Indeed it is no exaggeration to say that the whole art and science of psycho-analysis depends on a thorough understanding of the fluctuating activity of unconscious derivatives and the varying *right of presentation* they secure in the preconscious system. For this reason a useful preamble to the classification of mental mechanisms is to study the differences between primary and secondary processes. This can best be done by investigating the nature of *dream work*. The primary process of *condensation*, for example, is easiest to observe in dream formation (see *Dreams*), whereas the effect of unconscious mechanisms such as *displacement* can be studied also in (pre)conscious levels. Compromises between primary and secondary processes are best illustrated by the processes of *symbolism* and *rationalisation*, and of course in the case of mental disorder by *symptom-formations*. Above all the function of *repression* as a controlling agency must be kept constantly in mind.

Naturally enough the clinical psychologist is interested primarily in those mechanisms that are of service in controlling impulse or in promoting adapted behaviour, for the simple reason that *deficiency or excess of function of these mechanisms is likely to lead to mental disorder*. Some observers indeed are too exclusively concerned with the 'control' aspects of mental economy. They regard most mental mechanisms as *internal defence reactions*, forgetting that the ego has to face danger from without as well as from within. Although serviceable in a clinical sense, the term 'defence mechanism' tends to give rise to misunderstanding. A mechanism can be used for purposes of defence but it can likewise be used for more positive purposes, as when energies derived from separate instincts are co-ordinated and having imparted impetus to the pilot impulse, lead, e.g., in sublimation, to the effective discharge of instinct.

It is possible to classify mental mechanisms in a number of ways, e.g., according to the order of their emergence or primacy, their mobility or rigidity, their relation to consciousness or to ego-formation or again the frequency of their association with particular varieties of instinct-tension. None of these classifications is really satisfactory. Differences of opinion exist both as to order of emergence and primacy. In any case it is necessary to assume that the tendencies from which they are derived exist from birth. Moreover it should be remembered that the mind acts as a whole; in other words *mental mechanisms act simultaneously and collectively*. Their isolation is an artificial device adopted for purposes of presentation and in order to promote more precise clinical distinctions. Under these circumstances it would seem desirable to set aside any considerations of chronological order or developmental significance and fall back on purely clinical considerations. From this point of view the most important unconscious

mechanism is certainly that known as repression. *It was the first to be discovered, is responsible for some of the most characteristic features of mental activity, and, when its function is faulty, plays an important part in every variety of symptom-formation.*

REPRESSION. Unfortunately the term repression has crept into popular favour and is generally used to express the idea either of conscious suppression or of rigid upbringing. This error can be avoided to some extent by considering first of all the 'regressive' aspects of sleep, either as observed in the behaviour of infants or, using a light form of introspection, as noted during the process of 'falling' asleep. In the latter case it is not difficult to detect an *involuntary withdrawal of interest* from the external world which gradually limits the range of conscious thinking; in some cases the influence of unconscious distortion of conscious thinking can be observed, a process which is followed almost immediately by 'falling' asleep; in other words, cathexis is gradually withdrawn from the world of objects, later from conscious ideational derivatives of instinct and then, more abruptly, from all waking mental activity, either ideational or affective. Although this process is not identical with repression, the observer's incapacity to be aware of the actual 'falling' asleep and on occasion his incapacity to keep awake despite vigorous effort may give him some idea of the unconscious nature of repression in particular that part which is due to withdrawal of cathexis. In the case of repression however the mental content that has, as it were, been put to sleep, can 'wake up' only under highly specialised and limited conditions. It may indeed never have been a part of 'wakefulness' and remain perpetually 'asleep' although perpetually active.

This distinction between repressed content that has once been conscious and content that has never been conscious suggests what is in fact the case that we must distinguish at least *two stages in repression*, primary and secondary. Freud used the term *actual repression* to designate the second stage. Many psychologists who understand that repression is an unconscious mechanism nevertheless tend to think of it exclusively in terms of the second stage. Actual repression is so to speak the perfected mechanism and is therefore more easy to study and to describe. It is set in operation when the ego finds that owing to the anxiety provoked by frustration or to the censoring activities of the super-ego it is threatened with 'pain.' This discomfort is aroused when unconscious presentations of a primitive and tabooed impulse are activated and threaten to gain entry into the pre-conscious (pcs) system. The energy charge (cathexis) is then withdrawn from any representatives or derivatives of the unconscious impulse that exist in the pre-conscious system and which might permit communication with the original impulse. Actual repression is only successful, how-

ever, when it withdraws sufficient instinctual cathexis to prevent the appearance of affect in consciousness. The amount of energy charging the idea is of course much smaller than that giving rise to the affect. In successful repression the individual has not only no idea of the existence of the impulse but is completely unaware of any discomfort arising from its frustration. He cannot be made aware of it by any ordinary mental effort. *This withdrawal is effected by the deeper unconscious part of the ego. It is stimulated either by anxiety or by guilt arising from condemnation by the unconscious super-ego.* But withdrawal of cathexis is not the only activity involved in actual repression. In addition to withdrawing energy from the painful ideas, the unconscious ego 'goes out of its way' to *counter-charge* ideas other than those provoking pain (*anticathexis*). The process of anti-cathexis can be best understood by thinking of a child, secretly afraid of what is in one corner of a room, staring fixedly at some object in another corner (a 'not that but this' system). The withdrawing of energy and counter-charging take place on opposite sides of what might be called a repression barrier existing between the pre-conscious and true unconscious.

In view of the fact that actual repression occurs at the frontier between the unconscious (ucs) and the pre-conscious (pcs) systems and that the organisation of the pre-conscious is built up, for the most part, on verbal (word) representations, it is obvious that this mechanism cannot develop until the pre-conscious is definitely organised. And this gives us some idea at least of the earliest possible date at which actual repression can operate effectively, namely, sometime after verbal representation of experiences i.e., *speech*, has been sufficiently developed to enable the *meaning of thought* to be expressed in thought. These formulations enable us to approach the problem of *primary repression* with more confidence. It is clear that in primary repression there can be no question of withdrawing cathexis from pre-conscious ideas. At that primordial stage before subject-object relations are defined, before speech is organised, and before meaning is established, ideational derivatives are of the most primitive, concrete and mostly corporeal order (see also *symbol-formation*). We are therefore forced to assume that primitive unconscious drives are held in check by counter-interests which are mobilised by the overwhelming need to lessen the discomforts of frustration. With the most sympathetic of efforts we can only dimly apprehend the overwhelming anxiety aroused by helplessness in the face of powerful unsatisfied excitation. Freud expressed this in the statement that *primary repression depends originally on a form of anti-cathexis*. It will be seen therefore that the concept of primary repression is arrived at by a study of actual repression. It is a necessary complement to the theory of actual repression. The subject, in fact, requires much more elaborate investigation. For instance, although there can be no with-

drawal of pre-conscious cathexis in primary repression, yet in sleep a certain amount of withdrawal of cathexis from all three psychic systems takes place; and in schizophrenia, cathexis of unconscious content is considerably reduced. This suggests that the original regressive withdrawal of cathexis occurring in sleep paves the way for primary repression and that actual regression is an auxiliary to actual repression. Abstruse and impractical as these considerations may seem, they yet have an important bearing on clinical research. There is an increasing tendency in psycho-analytical circles to classify mental disorders in terms of their etiology, to classify etiological factors in terms of the developmental layers in which they originate and to classify developmental layers in terms of some one characteristic mechanism. Obviously it is important to recognise that although the mechanisms of actual repression cannot operate effectively until the second year of life, primal repression must begin to operate from the period when primordial memory traces begin to be organised. Attempts to correlate the deeper ego disorders exclusively with isolated mechanisms such as projection and introjection and to maintain that these mechanisms exercise a dominating influence over early ego-development can only end in confusion and error.

Actually most of the clinical correlations of repression with normal or abnormal function depend on the study of actual repression. Naturally the end results are easier to detect when the process of repression is *at fault*. In normal cases the effects of repression can be observed only by studying dreams, lapses of memory and a number of minor disturbances of function (see *symptomatic acts*). The 'psycho-pathology of everyday life', as Freud termed these lesser and fleeting mental disorders provides a field of investigation that can, up to a point, be explored with advantage by the everyday observer. It is easy to confirm for example, that slips of memory are due to withdrawal of cathexis from pre-conscious presentations having painful emotional associations. The link with unconscious content however cannot be established by ordinary introspection. In principle it is only a short step from slips of memory to the gross disturbances of memory that follow excessive or deficient function of repression. These disturbances are due to the fact that withdrawal of energy affects not only the unconscious phantasies that cause anxiety or guilt but also any ideas, however innocent, that may be associated with them. The most massive disturbances of memory occur in the amnesias, dissociations, somnambulisms and fugues of hysteria; and, incidentally, the analysis of hysteria produces by far the most dramatic 'recovery of memories'. Hence repression has come to be regarded as the principal form of hysterical defence. It is especially adapted to deal with infantile genital libido. But there is no doubt that earlier nuclei of the super-ego are capable of stimulating

repression and thereby of obliterating painful excitations of a pre-genital type. It seems however that repression is not very effective with sadistic overcharges, although by obliterating the libidinal components of the fusion between sexual and aggressive instincts, it enables these charges to be dealt with by other mechanisms and distributions.

Finally it should be noted that although repression is an ego-mechanism, it is one that leaves few observable traces in the conscious ego. In this respect, withdrawal of cathexis is a flight mechanism. The more successful the flight the less imminent the danger. On the other hand it might be said that since repression is instigated by a form of condemnatory judgement many conscious ego-formations can be traced back to the supplementary action of anti-cathexis. This view brings us at once to a consideration of the mechanism of reaction-formation.

**REACTION-FORMATION.** The anti-cathexes we have considered so far are, like the repression mechanism of which they are a part, highly mobile and specific for the unconscious excitation that induces them. The struggle between the repressed and the repressing forces ends in a conflict over the power of presentation of unconscious derivatives in consciousness. The more distant (and therefore safer) the derivative of a repressed impulse the more readily it secures power of presentation. But since instinctual problems are constant, leading always to an identical disposition of anti-cathexes, and since it is good economy to establish permanent as well as mobile anti-cathexes, it is easy to see that certain standard patterns are sooner or later bound to be imprinted on the structure of the ego. In reaction-formation the anti-cathexes (counter-charges) are highly specialised and developed into a permanently organised system. Ideas of a type antithetical to those repressed are heavily and persistently charged. Usually, the instinct employed for this purpose has an aim opposite to that of the repressed instinct. So that, for instance, the reaction formations aroused by unconscious rivalry and hostility depend mainly on love images and energies. Unconscious sadistic impulses are barred from the pre-conscious by a reinforcement of kindly thinking and behaviour, desire to injure is replaced by kindness or feelings of pity for the injured. Similarly with repressed anal interest. 'Soiling' phantasies are held in check by the reinforcement of ideas of bodily and mental cleanliness. In general, reaction-formations are directed against infantile pregenital forms of love and hate. They are built up from about the age of two onwards, but are tremendously reinforced in the latency period. They constitute some of the most permanent and recognisable features of normal character, and, when they are excessive, a number of pathological character-traits. Excessive scrupulosity, for example, is a typical response of the obsessional character. Excessive reaction-formation also plays an important part in the symptom-formations of the obsessional.

neurotic, although it is easy to infer that its very excess is due to a kind of compromise, i.e., that its function is to hold in check and at the same time to imply the gratification of a repressed impulse. In other words the symptomatic type of reaction-formation receives cathexes both from the repressing system and from the repressed. It requires little investigation of a hand-washing ritual, for example, to uncover early conflict over infantile masturbation closely associated with guilt over a sadistic reaction to its frustration: at the same time it symbolises the act of masturbation.

Owing to the part played by repression in hysteria, symptomatic reaction-formations do not figure prominently in that psycho-neurosis. They can, however, be observed in the hysterical character, and take the form mainly of exaggerated solicitude towards family and other figures of emotional importance (or their more immediate substitutes e.g. animals) who have aroused unconscious feelings of hostility. As will be seen, hysterical types do not displace so readily as obsessional types. The hysteric may be quite indifferent to the fate of 'outsiders' whereas the obsessional will, if need be, develop scruples over the life and behaviour of some total stranger living in the Antipodes.

It is sometimes thought that depressive systems are in the nature of reaction-formations, substituting passive attitudes for active impulses of aggression; as, for example, the development of attitudes of self-depreciation, self inhibition, and self-injury in order to prevent an uprush of active sadistic impulses. But in view of the reversal of instinctual drives that takes place, it is scarcely legitimate to explain depressive states purely in terms of reaction-formation.

**DISPLACEMENT.** Functionally regarded the drawback of reaction-formation is that it lacks the mobility of the anti-cathexis occurring in repression and that its success depends on maintaining an *opposition* of repressed and repressing forces. The *positive* gratification secured is largely secondary (moral) in nature, i.e. the merging of egoistic ideals with the dictates of the super-ego. Neither mechanism is adapted to the purpose of finding more outlet for modified forms of instinctual gratification. This is the main function of *displacement*, a mechanism which after repression is largely responsible for maintaining normal mental equilibrium, in other words, for securing effective adaptation.

In its barest essentials displacement can be described as an unconscious process of transferring cathexis from one set of representations to another, and thereby of transferring affects appropriate to one psychic situation to another. But it cannot be described satisfactorily without taking into account other factors; e.g., the nature of the instinct, the aim of the instinct and the original object of the instinct. The effect of displacement depends on whether the instinct concerned gives rise to conflict and is therefore subject to repression or whether the aim of the

instinct is consonant with the ideals of the ego but owing to developmental factors is no longer capable of satisfaction. In both instances frustration exists. In the course of development it becomes possible for the unconscious ego to transfer interest not only from one object to another but to transfer affect from one emotional situation to another. This can be studied most directly during psycho-analytical treatment. As the *transference* develops, feelings originally associated with parental figures are displaced to the analyst, and the analytic situation is reacted to as an infantile one. The process of transference is of course not limited to the psycho-analytic situation; it plays a part and a useful part in all human relations whether with concrete objects (both animate and inanimate) or abstract 'objects' (ideas). Hence it is responsible for the most astonishing variations in the range of interest manifested by different individuals or by the same individual at different times.

The *path of displacement* is ordinarily determined by the degree of resemblance existing between on the one hand the source, aim and object of the instincts concerned, together with the ideations and affects produced by them and on the other the displaced derivatives. Oral interest can be displaced from the nipple to the 'comforter' or thumb, in which case the displacement is determined by the similarity of the objects (the nipple, comforter, thumb) the similarity of the aims (sucking), and the similarity of the affective experience (pleasure in sucking). By a similar process unconscious genital anxieties originally displaced to the head and facial organs (eyes, nose etc.) can be changed first into morbid concern with mental processes; e.g., intellectual function, memory and powers of concentration, and later into actual disturbances of these functions.

But of all the manifestations of displacement the most exaggerated and at the same time most complex are those observed in the formation and spread of obsessional symptoms. One object after another is drawn into the orbit of the obsessional process, until the original obsessional idea or ritual is overlaid by a proliferating mass of obsessive thoughts or practices each of which on closer examination is found to have definite associative links with the previous one. The more logical of these links are contributed by the pre-conscious system; the more illogical, bizarre products are the result of more direct interference by the unconscious, a sign, in short, that unconscious cathexes are psychically too near to preconscious expression. But this more or less logical continuity can be interrupted by a number of factors, as when the similarity is based on an apparently *trivial point of resemblance*, or where the process of unconscious *symbol-formation* (q.v.) permits an apparently erratic spring from one point to another. Concrete objects may be changed to abstract, animate to inanimate. Again,



should the ego for its own purposes identify one object with another but dissimilar object, affect can be transferred on the strength of this *identification*. Despite these apparent illogicalities, which incidentally help to prevent conscious recognition of the operation of displacement, the psychic continuity of the process is unimpaired and cannot be interrupted except by the reinforced action of repression. Naturally the more illogical the path of displacement the more likely it is that some element of unconscious conflict exists. Displacement also occurs when the primitive aim of an instinct is modified, thereby permitting the freer transfer of the reduced cathexis to fresh objects. But as this process is closely associated with *sublimation* it is convenient to consider it under that more specialised heading. In fact study of displacement more than that of any other mechanism demonstrates how much the operation of any one mental process depends on the simultaneous action of other mental processes. And it is clear from the close association of displacement and transference with symbol-formation, identification and sublimation, that it must play an important part in promoting normal function.

But as in the case of all mental mechanisms, displacement can suit the purposes of regression as well as of evolution. It is a two-way mechanism and can act backwards as well as forwards. This does not mean that preconscious cathexes can be displaced backwards; it means simply that during the process of regression cathexes tend to retrace the path they originally followed. Regressive displacements may be transient, i.e., part of the ebb and flow of instinctual cathexes, or, if persistent, may lead to the formation of symptoms. In fact displacement plays an important part in determining both the form and the spread of symptoms. It occurs in most phobias; as, for instance, when unconscious fear of the genital organs of the parents is displaced to animals, wild, domestic or imaginary, which symbolically represent the feared organs. The 'infective' nature of the phobia-formation illustrates even more clearly the influence of displacement. Except in the case of monosymptomatic phobias, morbid anxiety tends to spread from one idea, object or situation to another.

Displacement also influences the localisation of conversion symptoms. Displacement from below upwards and from above downwards accounts for the discharge, in the form of conversion symptoms affecting the upper and lower extremities of the body respectively, of unconscious tension and guilt aroused by repressed genital interest.

**AIM-INHIBITION.** In describing reaction-formation and displacement the accent has for the most part been laid on the vicissitudes of *ideational derivatives* of instinct. And, as we shall see, the fate of these instinct derivatives is also important for sublimation. At this point,

however, it is necessary to consider what modifications the original instinctual *forces* may undergo: for, as the case of repression clearly shews, the success of any defence mechanism depends on reducing the force of the instinct drive responsible for mental discomfort. A transitional form of mental activity, half-way between repression and sublimation, is to be observed in the process of *aim-inhibition*. As we have seen, the original libidinal drives of the child towards its parents comprise a number of infantile sexual components having a variety of erotic aims. Hence the love reactions of the child are constantly disturbed by affects derived from zonal sexual excitations together with the anxieties and hostilities engendered by their frustration. In aim-inhibition the total libidinal drive is reduced by the elision of conflict-producing erotic components, leaving however a substantial amount of libidinal outlet in the form of 'tender' feelings towards the parents. Love, tenderness, admiration, idealisation, and respect permit some positive gratification of the original drives. This process is accelerated by the development of thought and speech, as the result of which the ego becomes less and less a 'body' or 'corporeal ego' and is influenced more and more by purely psychic relationships. As has been pointed out, once the more primitive aims of an impulse are eliminated (in this case, inhibited) the mind can deal freely with residual drives by means of displacement and substitution.

It is permissible to regard aim-inhibition as a result of *part-repression*. The important point is, however, that no *qualitative* change in the original charge of instinct take place; the attitude to the object is altered by a process of elimination of primitive elements; *positive* gratification of some of the original cathexis is allowed. Naturally the process of aim-inhibition is greatly encouraged by the policies of the parents, who not only reject (directly or implicitly) the erotic urges of the child but display only aim-inhibited reactions to the child.

Aim-inhibition can be observed not only in childhood but again in adolescence and adult life when it plays a part in the process of falling-in-love. Indeed during the period of courtship the process is quite a conscious one. The original inhibition is, of course, quite unconscious. Clinically the process of aim-inhibition provides a useful criterion of the severity of sexual and marital disorders. Absence of tender feeling towards the sexual or marital object indicates either that the difficulty is a deep-seated one or that the dichotomy between erotic and psychical forms of love has not been overcome at puberty.

**SUBLIMATION.** Armed with the concepts of aim-inhibition, reaction-formation and displacement or substitution, we can approach the much-misunderstood mechanism of *sublimation* with some confidence. The function of true displacement can be approached from two

angles, namely, the degree to which it acts as a *defence* against the emergence of repressed impulses and the degree to which it provides or leads towards *substitute* goals for frustrated instinct. Understanding of this dual function permits a ready distinction between displacement and sublimation. The main aim of sublimation is to provide a *positive* outlet for frustrated infantile sexual components, *on the condition however that the original (primitive) aims of the impulses are permanently modified*. If this proviso, which can be attributed to the activity of the super-ego, is fulfilled, sublimation opens up innumerable avenues of discharge. Although therefore displacement and substitute-formation figure prominently in sublimation, there are two stages in the process, first, modification in the *aims* of the original instinct and, second, displacement from the original *object* of the instinct to a substitute object or objects.

In the case of sublimation, the alteration in the aims of sexual instinct are due not to repression or to inhibition of erotic elements but to *a radical and permanent change in the energy of the instinct*. Although we cannot say precisely how this change is effected, we can indicate with certainty the point at which it takes place, namely, when infantile libido is withdrawn from its original objects. The withdrawal is due to a combination of factors, viz., frustration, external disapproval and super-ego interference. When psychic energy is withdrawn, it is in a sufficiently 'free' state to undergo modification. If, for example, love and hate attitudes are combined (fused) in an object-relationship, the withdrawal of cathexis permits a *defusion* of the previously combined forces. The libido that is set free can now undergo further modification and become *desexualised*. In this more or less neutral form, it is readily capable of being diverted to new (but now non-sexual) aims or objects, indicated by the ego and sanctioned by the super-ego. For example, infantile sexual curiosity can be sublimated in the form of social curiosity and thereby enhance enormously the individual's capacity to learn. Similarly anal impulses when sublimated can be expressed in aesthetic interests and the original reaction-formations against anal interest changed into socially useful forms of tidiness etc. The process of *diversion* constitutes the second part of the mechanism of sublimation. Desexualisation alone is not sublimation; the freed and neutral energy must follow paths of displacement.

If this were the only source of sublimated energies, the process would seldom get out of order. But a great deal of infantile libido is autoerotic in nature and, when frustrated, disturbs the narcissistic balance of the ego. This too has to be sublimated; and since withdrawal from the narcissistic aspects of the ego is never so thoroughly effected as withdrawal of object-libido, sublimation in practice is frequently faulty.

There are therefore two clinical aspects of sublimation – progressive

and regressive. In the positive progressive sense, they contribute enormously to the stability of the individual. So much so that the *breakdown of sublimations is a clinical danger signal*, indicating that the whole economy of libidinal discharge has been radically disturbed. Moreover, gross interference with or frustration of sublimations can act as a precipitating factor leading to the formation of symptoms. The efficiency of the mechanism can be roughly estimated by measuring the individual's working capacity and enjoyment, together with his social and individual recreations and hobbies. Sublimations can be disturbed by faulty function of repression, in which case unconscious cathexes, acting along the path of displacement, are attached to the sublimated activity and either bring about its inhibition or convert it into a symptom-formation. This explains why so many obsessional formations appear to be caricatures of sublimated activities.

It will be seen that starting with primal repression and following the vicissitudes of instinctual cathexis and of the presentations they activate, we have covered a wide range of psychic activities, each one more complex than the last. This increased complexity suggests a rough order of development; but too much importance should not be attached to this question of precedence. The apparent complication of the psychic mechanisms described is due largely to the part played by the pre-conscious system and its anticathexes. From the unconscious point of view there is a good deal of overlapping of the various mechanisms, all of which function simultaneously. Before proceeding to consider the mechanisms that are responsible for the outline and internal structure of the ego, we must consider some varieties of mental mechanism which certainly begin to operate at an early stage of development, about the time when the narcissistic organisation of the mental apparatus is being weakened by a gradual distinction between the 'self' and the 'not-self.'

It was Freud's view that all modifications undergone by instinct are subject to the influence of the three great polarities that govern mental life. These are respectively the polarities of Activity-Passivity, of Subject-Object (later ego-external world), and of Pleasure-Pain. Freud also held that, prior to the development of repression, these influences manifest themselves in certain primal vicissitudes of instinct. Thus an instinct can undergo *Reversal into its Opposite*, and *Reflexion on the Subject*; and it can be controlled by a primitive form of *Denial*. Clinically, *reversal* is best illustrated by the change of *aim* from active to passive undergone by sadistic impulses when they are transformed into secondary masochism. *Reflexion* can also be observed in the Sadism-Masochism couple, where violence directed towards an *object* is first *turned on the Subject*. This is a transitional (reflexive) stage in the de-

velopment of a true masochistic relation to an object (when the *object* directs violence towards the subject). Since the existence of these early vicissitudes can only be inferred from behaviouristic data, they are apt to be confused with later manifestations, such as the withdrawals of object-cathexes and changes of aim that occur when the ego is already differentiated into the real-ego and the super-ego. It is essential to distinguish clearly between these later developments and the earliest forms of instinct modification that are associated with the phase of primary narcissism. This can be more easily grasped by remembering that the flow of instinct-excitation can have a regressive as well as a forward direction. It is reasonable to suppose therefore that excessive excitation or excessive frustration of active drives should lead to a reversal of this flow. This can be seen clearly enough in the processes of dream-formation: instinctual cathexes being unable to obtain discharge at the motor end of the apparatus flow back to the sensory end and give rise to hallucinatory forms (visual images) of activity. Moreover the fact that certain other instincts can be gratified on the self without the interposition of the external world (see *Autoerotism*), puts a premium on narcissistic regression in the face of external frustration. Finally, the fact that for a time the existence of external objects and the part they play in instinctual gratification is not realised by the infant, reinforces its tendency to avoid frustration by turning the frustrated instincts on (what the observer knows to be) the self. From this point of view primitive *reversal* and *reflexion* are seen to operate from the blind force of psychic necessity. They are of course palliative in action. When the limits of their capacity have been reached, there are only two courses open to the infant; either to discharge its discomfort through the motor end of the apparatus, thereby calling the attention of the external world to its state of 'pain,' or to regress further by falling asleep and mobilising hallucinatory wish-fulfilment.

The influence of the third polarity, viz., Pleasure-pain is seen in the primitive mechanism of *denial*. Like primal repression, this is a forerunner of actual repression but depends less on the operation of primary anti-cathexes than on the success of hallucinatory wish-fulfilment which by attracting energy to the sensory end of the apparatus and thereby providing a marginal state of gratification gives the infant breathing space to withstand the full force of frustration. During this breathing space denial occurs.

Some understanding of these early vicissitudes is a useful preliminary to the study of projection.

**PROJECTION.** Some observers regard *projection* as one of the earliest forms of unconscious mental regulation. This may be true of its primitive forms but it is not so certain that the complete mechanism is

much earlier than repression. Primary projection depends on a peculiarity of the mental apparatus. From the point of view of consciousness all stimuli whether coming from the external world or from the internal (endopsychic) Id can be said to 'come from without' in the sense that they impinge on or pass through consciousness. Moreover the mental apparatus for some time after birth is not able to distinguish between the self and the not-self. Only gradually does the child realise that whereas some stimuli can be escaped from by (motor) flight or can be removed with the help of (what ultimately proves to be) external agencies ('not-self'), others cannot be so escaped from and are irrevocably linked with the 'self.' In projection the mental apparatus tries to turn these escape experiences to advantage in order to cope with the discomforts of inescapable frustration. States of tension are not only *denied* but attributed to some external agency (*object*). When for example, during a shopping expedition an older woman tells her friend rather tartly the hat she is about to purchase is 'much too young for her', we may be certain that she is anxious to conceal her own age. When a paranoiac maintains that his neighbour is injuring him by wireless waves and goes on to smash his radio set we can be equally certain that he has projected his own hostility on the neighbour whom he then attacks. He has converted an active internal stimulus into an external one. Also, activity has been transferred into passivity. Instead of experiencing the discomfort of active unconscious hatred of an object he is convinced that someone else hates him and reacts to this illusory external danger with anxiety, flight or anger.

It will be seen therefore that projection has some resemblance to repression and displacement. It resembles repression in that it operates unobtrusively: so far as the individual is concerned he is completely unaware of a painful impulse. But although he is unaware of its existence, the painful affect arising from the excitation is not eliminated, it appears as a response to the alleged behaviour of an external object and later of a series of objects. So that not only does subject-object reversal take place, but displacement occurs. In a sense projection is the best example of an anti-cathexis, which takes over the original unconscious cathexis. In successful repression of course no affect of any sort is experienced.

Projection is constantly used by normal persons to lessen the current tensions of hostility, but is found more frequently in persons whose sexual adjustment is not very satisfactory. It therefore figures prominently in marital conflict, in certain types of alcoholism and drug addiction, and of course in the delusional systems of paranoiacs and paraphrenics. It also plays a part in the formation of phobias where an internal danger is denied and regarded as coming from without. Interestingly enough projection is commonly regarded as a pathogenic

tendency of the mind. Actually it is no more pathogenic than any other mechanism. Only faulty projection is pathogenic, or more accurately, is followed by pathological manifestations. The distinction between so-called 'normal' and 'abnormal' projection is purely clinical. The success of any mechanism is rated by the degree to which it contributes to mental stability and effective adaptation.

**REGRESSION.** Whatever doubts may exist as to the order of emergence of other mental mechanisms, there is no doubt that *regression* operates from the moment primordial memory-traces are laid down. It is a characteristic of mental function alike in sleeping and in waking life, in health and disease. Psychic excitations that have advanced in any given direction can and do retrace the path along which they have advanced. It is not surprising therefore that the mind when disturbed by states of mental pain should attempt to deal with this by withdrawal of cathexis from the current situation to an earlier position. The ultimate direction of all regressions is of course towards the Id. In its simplest form regression consists simply in a withdrawal of cathexis which immediately invests the antecedent presentations; but as the mind develops it can withdraw interest periodically from any variety of psychic contact (relations to object or modes of gratification) and either reinvest earlier psychic relations or reactivate earlier modes of gratification. This is easiest to observe in the regression of adult sexuality to infantile forms and aims. But although regression is commonly associated with movements of the libido, regression of the ego to earlier forms of organisation also occurs. Ego-regressions are in principle directed towards the re-attainment of a state of narcissism; but except in the normal regression of sleep, this is never achieved even in states of gross mental disorganisation. Ego-regressions are in any case rarely 'total' i.e. involving the whole ego. Much more common is a partial regression of the ego; in other words, regression usually reactivates that part of an earlier ego-organisation which was originally involved in instinctual conflict.

These selective goals of regression necessitate the use of a special term, viz., *fixation*. Like regression, fixation can be thought of in terms either of instinct or of ego-levels. Instinctual fixation can be brought about either by excessive gratification or by severe frustration of infantile instinct or component instincts. Both tend to retard advance to the next stage in development and so form fixation points. Also, rapid alternation of and sharp contrast between experiences of gratification and frustration at any point in early childhood tend to give rise to a fixation of instinct. Fixations are sooner or later subject to repression and thereby remain actively cathected. This explains the *power of attraction* existing at a fixation point. As has been suggested, ego-

regressions extend back to the level at which infantile conflict was originally most acute or to the point where the early ego was most successful in dealing with frustration. Part-regressions usually activate one or more ego-nuclei. We are therefore able to distinguish (a) normal and pathological types of regression, (b) instinctual and ego regressions and (c) total or partial regression.

The operation of 'normal' regression can be easily studied in the phenomena of sleep, dreaming, phantasy-formation, day-dreaming, or the regressions of character and libido occurring in advanced age. The corresponding indications of pathological regression are insomnia, disturbances of memory and orientation, absence of mind and the psychic manifestations of senility. Like all other unconscious mechanisms regression plays an important part in symptom-formation. Superficial withdrawal of interest from social and/or sexual relations is frequently a sign that a mental breakdown is impending. So much so that persisting withdrawal of actual contact, followed by an increase in phantasy thinking has been given the special designation of *introversion*. Introversion occurs normally but is not followed by serious regression. The term has a strictly limited connotation and should not be confused with the 'introversion' described by Jung. Clinically the most important regressions are those which, on reaching the unconscious fixation point, activate an old infantile neurosis or psychosis. When that happens symptom-formation is certain to ensue.

It has become the custom to speak of some mechanisms as if they ran in couples. Projection and introjection for example are often referred to as constituting a fundamental economic antithesis. Strictly speaking this usage is misleading. Whereas projection is adopted by the mental apparatus to deal with excessive instinctual strains, it leaves little imprint on the ego. Introjection on the other hand is responsible for the development and subsequently the differentiation of the ego.

**INTROJECTION.** Little is known of the actual nature of introjection processes. As in the case of projection the infant's incapacity to distinguish between internal and external stimulation prepares the way for a confusion between the self ('me'-ego) and the object of instincts ('not-me' - outer world). This confusion which is essentially a narcissistic phenomenon is sometimes referred to as a *primary identification* (see identification). But in contrast to projection, which is derived from a necessity to *expel* painful stimulations from the psyche, introjection is derived from an early infantile wish to *retain within the self* those pleasure experiences which in reality depend for their renewal on objects in the external world, e.g., the longing to retain permanent control and mastery over the mother's nipple (or bottle) and so avoid



the anxiety of oral frustration. This primary tendency of the mental apparatus is reinforced by the fact that the earliest and most important aim of the infant is an oral one and is achieved by taking the object (nipple) into the mouth and swallowing the fluid extracted from it by sucking. There are of course other corporeal means of making the object behave as if it were part of the self, e.g. grasping, pulling and holding; but in the pleasure sense these are not so impressive as the temporary incorporation of the nipple and actual incorporation of milk. So it is a safe assumption that the primordial memory-traces that go to build up the body-ego consist of oral impressions. Put more technically the first attitude to (what the child knows later to be) an object is one of taking in and swallowing. And in so far as oral gratification alternates with oral frustration the feeling attitudes must be an alternation of pleasure and love with a tension that immediately arouses anxiety and aggression. No doubt the aggression (hostility to what is later known to be an object) exists from the first but it is sharply accentuated when, with the eruption of teeth, the biting phase of oral interest commences and adds to the effective power of the infant's oral-sadism. For these amongst other reasons, it is customary to refer to the process of introjection as the psychic equivalent of oral incorporation, *as if* the ego (a mental institution) had 'swallowed' the object (an imago). Nevertheless the process is purely energetic: the energies appertaining to the ego are distributed *as if* they were subject to the control of the object-imago.

These psychic events are not of course directly verifiable and in any case the processes are described by means of an *oral analogy*. They are either plausible reconstructions in terms of basic concepts or are inferred at second-hand from the analysis of the depressive states. Direct evidence of the existence of introjection is obtained by the analysis of children between the ages of three to five and is confirmed by analytic investigation of adolescents and adults. It is easy to demonstrate that when the child abandons its most advanced (genital) incestuous drives it begins to behave in a way which suggests that parental attitudes to infantile sexuality have developed *in* the ego, or in more simple terminology, that parental functions have been 'taken over' by the ego. And as we have seen these acts of introjection are responsible for building up or completing the super-ego. This was originally expressed by Freud in the saying that incestuous attachment to the parents is *replaced by identification* with them. In those days introjection was used to describe the *aim* of 'psychic intake' whilst identification described the relation to the *object*, but, since the advent of super-ego psychology, the tendency has been to regard introjection in structural as well as in dynamic terms.

To this point we shall return. In the meantime it must be admitted that

what happens between this later stage of super ego formation which is brought about by introjection proper and which can be demonstrated by direct analytical observation and, on the other hand, the phase of primary introjection which is reconstructed only by inference, is not very well understood. Psychically regarded the 'object' of an instinct is represented in the mind by a nexus of images, impressions and associated emotions. These emotions may be pleasurable or painful, in accordance with the amount of gratification afforded or frustration caused by the object. When frustration becomes absolute as in weaning, the tendency to take over and retain in the ego what really appertains to the object-world is overpowering. Now it is significant that between the period of weaning and the stage when the Oedipus situation is finally abandoned, a series of pre-genital relations to objects exists, all of which have in turn to be abandoned (see *libido-development*). We are entitled therefore to postulate a *series* of introjections each one superimposed on the last, and it is reasonable to assume that *the necessity for introjection varies according to the degree of abandonment of the object*. When an abandoned object was originally associated with pleasure, the absorbed imago is felt as if it were a 'good' part of the self. If it was associated with predominantly painful experience it is regarded as a 'bad' part of the ego. In the earliest phases there is more chance that the result of introjection will be felt to be 'bad.' And this for a number of reasons. The more primitive the demands of instinct the more violent the frustration; the more violent the frustration the more sadistic is the infant's reaction; the more sadistic the reaction, the more does the child project this sadism on the parents, thereby converting them into 'bad' objects. Naturally all these tendencies are accentuated by actual 'bad handling' on the part of the parents, who, at the best of times, are capable of both witting and unwitting stupidity and sometimes actual brutality in the bringing-up of children.

When early introjections set up painful tensions or when 'good' introjections are disturbed by later frustrations the mind tends to revert to the practice of projection. A vicious circle is established – projection of painful impulse, introjection of 'bad' imagos, re-projection of painful tension. This can only be broken by increasing 'good' (pleasurable) experience in the self, by an increasing appreciation of 'good' behaviour on the part of the parents or by actual increase in love on the part of the parents. Naturally any fresh frustration tends to make the 'bad' states worse. Normally all infants alternate between 'good' and 'bad' states of this sort, and would remain in alternating mood were it not for the help of repression which, by obliterating all traces of the impulse puts an end to frustration. The first effect is that, instead of violent swings between 'good' and 'bad' feeling, a fusion of 'good' and 'bad' takes place (combinations of good and bad introjections). These fusions, although

an improvement on exclusively 'bad' feeling, are still extremely disturbing. Only when 'good' introjections predominate can development proceed satisfactorily.

It is often thought that anal, visual, auditory and even skin experiences contribute to the development of psychic introjections. The view is based on a study of unconscious phantasies, e.g. that objects enter the body through every known aperture and remain inside. This is thought to play a part in the phenomenon of anal interest in which faeces are treated as objects and retained or expelled accordingly. But primarily these attitudes to body-objects are a product of narcissistic organisation; and 'introjection phantasies' as they are sometimes erroneously called, are derived in the first instance from pleasure-pain experiences made during this stage.

Correlation of introjective processes with clinical phenomena is most clearly established in the graver ego-disorders. The exclusively 'bad' states described above are repeated in the depressive reactions of adults. Alternations of 'good' and 'bad' states appear in the manic-depressive psychoses and paraphrenia. Introjection is also responsible for the various forms of hypochondria. In obsessional systems, mixed reactions accompanied by acute ambivalence play a significant role. In conversion hysteria introjection is also a factor; but in the transference neuroses generally, the process is considerably modified by the operation of other mechanisms.

**IDENTIFICATION.** As has been indicated, a certain lack of precision has developed in the use of the terms introjection and identification. They are frequently employed as if they had identical meanings. Originally distinction was effected by reference respectively to the *aim* of the process (in introjection) and the *object* of the process (in identification). Now the characteristic of introjection is that the object functions *as if* it were *part* of the ego; and on the other hand identification often is, and indeed, from the point of view of empathy and adaptation, must often be, a transient manifestation leaving the object-relation unimpaired. Moreover the process of identification is not exclusively associated with the relation of the ego to any given object. The ego can identify objects with one another and can identify with an object through a common identification with yet another object. All of which would seem to suggest that as the infant mind develops and the relation of the self to external objects becomes more realistic, earlier introjective processes are replaced to quite a considerable extent by systems of identification. This process is not so 'wholesale' as introjection. From the first the object of identification is not only clearly recognised as existing in the external world but relations with the object (more accurately with its *imago*) are never so completely abandoned as in

the case of introjection. The basis of identification though not yet entirely realistic, is more elaborate, i.e. the imago is more like a person than like a set of gratifying or frustrating organs. Identification can still be divided into 'good' and 'bad' in accordance with the ego's reactions to the objects identified with. For example, the child can unconsciously increase its feeling of stability by identifying with parental objects who exercise powers, rights and capacities which children do not possess. It can model itself on good parental objects and so feel them to be part of the self. But in so doing the child still lays itself open to criticism. The 'good' objects of identification proceed to exercise criticism over 'bad' unconscious impulses in the ego, thus continuing, although in a less primitive way, the super-ego reactions produced by introjection. The more complicated forms of unconscious mental conflict are due to the interplay of opposing identifications. Hence identifications may figure prominently in symptom formations, particularly in the transference neuroses, some sexual perversions and a number of marital difficulties. Identification is responsible for the element of mimicry in hysteria, when, for reasons of unconscious self-punishment or reparation, the patient 'takes over' the illness of one or other parent. Indeed the element of mimicry observed in this disorder throws some light on the origin of the identification process. The most effective means of communication between the infant and its parents in the period before speech develops are, first, abreaction of affect e.g. crying, smiling etc. and, second, mimicry of gesture. And in fact Freud regarded identification as the most primitive form of relation to an object i.e. a love relation that precedes and paves the way for true object-love. The influence of father and mother identifications is very obvious not only in normal falling-in-love but in both male and female homosexuality.

**PRECONSCIOUS ASPECTS OF MENTAL ACTIVITY.** We must now consider some mechanisms which, although essentially unconscious in operation, play an increasing part in pre-conscious activity. Generally speaking the earlier or deeper the mechanism, the more its functioning goes undetected by consciousness. This is clearly demonstrated in the action of repression. In later types of mechanism, e.g., reaction-formation, a good deal of the activity can be observed in the pre-conscious system. The underlying causes of this activity are not, however, appreciated by the conscious mind. This lack of appreciation is the result of a special mechanism, which operates chiefly in the pre-conscious system.

*Rationalisation.* The last line of unconscious defence goes by the name of *rationalisation*. The mind has an almost incurable tendency to account for its thoughts, feelings and behaviour in rational terms.

This process of rationalisation aids and abets the purposes of unconscious concealment. For not only do the individual's explanations appeal to himself, they are likely to be taken at face value by his fellows, who, having similar unconscious conflicts, are disposed to 'live and let live'. Types who 'see through' the rationalisations of others and make a point of uncovering them are usually reinforcing their own projective defences. Amateur 'analysts' possessing at best a garbled knowledge of unconscious mechanisms and not a few trained psychoanalysts who ought to know better are sometimes guilty of this form of discourtesy. And just as the sufferer from delusions of persecution is never entirely wrong (i.e. when he projects hatred on others he takes unconscious advantage of the fact that there is always some hatred lurking in the human mind) so the person who detects rationalisations in others may be right: but he is right for the wrong reason. Rationalisations vary in depth and complexity. The deeper they are the more they resemble the '*secondary elaborations*' occurring in dream formations, where the manifest content is rounded off and given a more rational aspect, thereby screening more effectively the latent (unconscious) content of the dream. (q.v.). The more primitive the rationalisation the more it acts as a cover for psychic disorder: but needless to say it is constantly employed to cover the minor or major conflicts of everyday life. It must of course be distinguished from deliberate lying and prevarication; but in principle it differs only in that the individual is unaware he is lying or prevaricating.

Clinical psychologists have ample opportunity of studying rationalisations when taking case histories. The reasons given by patients to account for their abnormalities are almost invariably rationalised. Obsessional neurotics are expert at this unconscious game, whilst conversion hysterics are quick to find organic rationalisations to account for their functional crises. A toper will account for his morning retching on the grounds that he has eaten something that disagreed with him. The rationalisations of hysterics are notoriously exaggerated and to the casual observer give a false impression of being wilfully deceitful.

*Illusion Formation.* By way of contrast with rationalisation in which 'reasons' are fabricated in order to *cover* unconscious motives, illusion formation depends on the *manipulation of external perceptions and realistic ideas* by unconscious wish-formations. In perceptual illusion, the hallucinatory elements are mingled with real perceptions. The result resembles hallucination but differs from hallucination in that the result does not go beyond falsification of reality. Illusion formation may and frequently does reduce the pre-conscious state of frustration which accompanies deeper dissatisfactions with reality. It can often

be detected for an hour or so after wakening from particularly vivid dreams, a fact which indicates that it belongs, like delusion and hallucination, to the projection group of defences. It occurs frequently in hysterical character-formations.

*Wit-Catharsis.* Another variety of manipulation of pre-conscious content by unconscious processes is found in the mechanisms of wit. Here the logical activities of the pre-conscious are subject to unconscious manipulation in the same way that dream elements are subject to condensation, distortion, displacement, etc. (see *dream work*). By this means a set of ideational presentations is produced that brings about a minor but essentially cathartic discharge of affect. This is due to a temporary merging of pre-conscious anti-cathexes with a quantum of unconscious cathexis. The super-ego, satisfied that the discharge is purely verbal raises its censorship for a fraction of time. Of its nature wit-discharge is more commonly associated with normal than with disordered mental function.

*Volitional and affective aspects.* Largely because of his pre-occupation with mental disorders, the psycho-analyst's concern with pre-conscious function is usually limited to those mechanisms, derivatives and anti-cathexes that operate in concert with unconscious defences to prevent the emergence of forbidden unconscious wishes. To this extent the psycho-analyst has left a fertile field of observation to the so-far-not-too-fruitful cultivation of the descriptive and mensurational psychologist. It is impossible, however to study unconscious mechanisms and their preconscious auxiliaries without realising that the function of the whole pre-conscious system, even in its most rational and logical aspects, is influenced by laws which have been derived in their turn from earlier unconscious mechanisms, or more accurately, from the modification of unconscious laws by reality experience and reality thinking. The part played by these modified mechanisms in bringing about effective adaptation is literally incalculable.

On the other hand, pre-conscious formations, because of their apparently rational aspect, often serve to conceal pathological tendencies. Sometimes it is difficult to know whether or not to regard them as pathognomonic. When for example we observe lack of concentration and absent-mindedness in everyday life combined with an obsessive type of thinking, we jump to the, usually correct, conclusion that we have to deal with superficial manifestations of a psycho-pathological state. But we do not make the same diagnosis if we are informed that the individual in question is a passionate research scholar, who is in the habit of excluding all extraneous sources of 'interference' in order to concentrate the more closely on an absorbing problem. Nor do we

regard the function of perceptual-consciousness as abnormal when we discover that in course of development this mental system has acquired the capacity to defend itself against a disturbing influx of stimulations by 'cutting off' (paying no attention to) a vast number of perceptions. If however a hysteric complains of disturbances of vision or tells us that she is sometimes unable to see a person of emotional importance who is actually standing in front of her, we do assume that an unconscious conflict has not only penetrated the pre-conscious layers but has succeeded in throwing out of gear the sensory receptors of perception. When we observe a sudden introversion of interest from actual contact with objects to phantasy life, we do well to look out for trouble. But we do not therefore conclude that day-dreaming or phantasy-immersion is necessarily a disordered state. On the contrary without a capacity for phantasy thinking it is unlikely that man would have made more than the most feeble and intermittent efforts at scientific discovery. And for the matter of that in the absence of the libidinal satisfactions of thinking, little progress would be made in any form of cultural expression. *The capacity to distinguish between normal preconscious function, eccentricity of pre-conscious function and pathological function is in fact a distinct clinical asset.* In doubtful cases diagnosis often depends on being able to infer unconscious conflict from details of pre-conscious function. To do this with any accuracy it is necessary to be familiar with the developmental *sequence* of different groups of mental mechanism.

The *serial order* of mental mechanisms is easiest to observe in the case of the repression group. Starting with primary repression, and primitive forms of deflecting cathexis (denial), we soon find ourselves on the hither side of the repression barrier studying the anti-cathexes of reaction-formation. As we have seen, the varnishing process that covers some of the crudities of reaction-formation, displacement and substitution is provided by rationalisation. It is a short step, however, from rationalisation to *fabrication*, *prevarication*, and *lying*. Actually it is now well recognised that especially in childhood states of phantastic lying (*pseudologia phantastica*) exist which are due directly to the hyper-cathexis of unconscious phantasy. We can see also that conscious *denial* which is observed in an exaggerated form in negativism is derived originally from the repression group of mechanisms. It differs in one dynamic respect, namely, that conscious denial is more often a preliminary to assent than unconscious denial.

In many instances however pre-conscious mechanisms arise from a combination of unconscious tendencies. Thus refusal to pay attention or 'take in' what is happening is a combination of a repression and a projection mechanism which at the same time denies the libidinal source of the stimulus and conceals the hostility aroused by its frus-

tration. Lack of concentration, even in its most useful forms, is obviously due to the prior claims of unconscious phantasy or to the disturbing influence of conflict. But if we probe a little deeper we find that any exaggeration of introjective processes will bring about a like effect. Again methods of acquiring information, although obviously dependent on sublimation of more primitive impulses of curiosity, owe a good deal of their vigour to both the projective and the introjective tendencies of the mental apparatus. Excessive or frivolous systems of acquiring information are also influenced by introjective processes but indicate too the existence of repressed oral and anal phantasies. Obstinate argumentation apart from its obvious uses as a displacement of unconscious hostility, is a defence derived also from reaction-formation and projection, reinforced by repressed curiosity.

Each of these pre-conscious forms of defence is associated with *appropriate moods* which are similar in tone to those associated with the operation of the unconscious 'root-mechanism'. Hence the study of conscious affects is often of considerable value in differential diagnosis. It is necessary, however, to recognise the relation between the affect and the instinctual stress that calls the mechanism into operation. A purely descriptive assessment of affect is practically valueless. Thus, when we find that a person has optimistic feelings or entertains sanguine hopes or expectations, we must not overlook the fact that these states of mind, (attitudes, sentiments) are merely end-products of a lengthy series of mental mechanisms. Whereas in illusion there is a projective falsification of reality, in hope and expectation a temporary process of introversion occurs, leading to the reinforced cathexis of anticipatory phantasies. This actually provides a marginal gratification of instinct. Optimism is not just a state of feeling; whether true or false it is a preliminary phase of instinctual gratification. Whether the ego will be content with this marginal gratification is another story. In general the affects experienced in everyday life are secondary affects in a state of fusion (see affects).

To conclude this extremely brief and cursory survey of the volitional aspects of mental activity, we may consider one more example of the relation between unconscious and pre-conscious mechanisms. It is often said that in the absence of extrinsic factors, e.g. economic necessity, choice or change of occupation is entirely subject to conscious volition. But as the discussion of sublimation has shewn, the unconscious factors leading to this process are all important. In many cases it is the pilot-impulse of an unconscious sublimation that determines its ultimate form, the requisite momentum being imparted to the sublimated aim by deflection of neutralised libido. *In such cases conscious choice is little more than an intellectual ratification of a pre-determined decision.* At the same time it is significant that real freedom



of choice is also operative in the sublimation group, suggesting that the factor of *unconscious interference* is in such instances at a considerable discount. The concept of psychic determinism is one that usually provokes discomfort in the minds of laymen as well as metaphysicians. This difficulty can be overcome by remembering that pre-conscious function is interposed between the unconscious wish and its conscious discharge. The ego, in other words, remains nearest to reality, and, non-conflicting instincts apart, is capable of acquiring a considerable degree of mastery over unconscious impulse. To this extent it may may rightly claim that it has acquired some 'freed-will'. As however study of mental disorder clearly shews, this exercise of freed-will is precarious and contingent on the effective function of defence and discharge mechanisms. Adaptation through an efficient mental economy is the key to mental health.

*Intellectual Activity.* The tradition that intellectual processes are the appropriate preserve of the 'conscious' psychologist, that they can be adequately examined by methods of descriptive classification, by mensurational procedures, or by factorial analysis, and that the authority of the clinical psychologist extends only to gross interferences, such as amnesia, hallucination or delusion formation, is one that dies hard. Yet a moment's consideration will shew that although the intellectual processes are, more than any other form of mental activity, amenable to conscious and logical forms of controlled investigation, the results obtained cannot possibly satisfy the requirements of the 'unconscious' psychologist. While the latter is ready to agree that constitutional factors play a large part in their development and that psychic perception and the capacity for making psychic correlations are essential to the development of reality sense and are, therefore, functions of the real ego, he maintains that it is impossible to understand either normal or abnormal function of the intellect without examining the unconscious and pre-conscious elements that originally contribute to its development and later advance or retard its function.

In the present connection it is sufficient to indicate the most important metapsychological factors that bear on intellectual development. These can be divided as usual into dynamic, structural and economic. Dynamically speaking the most important factor is that of *mobility of cathexis*. It is clear that whatever interferes with the cathexis of psychic presentations must interfere with the efficiency of the intellectual faculties. It is interesting, therefore, to recall that the primary instincts vary in their lability. Sexual impulses are more readily displaced than aggressive impulses. On the other hand libidinal cathexis is more readily withdrawn. Aggressive instincts are not so labile, are not so easily withdrawn and are therefore controlled better by anti-cathexis. These

main instinctual tendencies are reflected in intellectual development. The sexual instincts when sublimated contribute to mobility of thinking but under unfavourable circumstances, i.e., when unsublimated and in a state of stasis, they render thinking processes liable to massive interruption. The aggressive instincts tend to produce rigidity and inhibition of thinking faculties but under more favourable circumstances add to precision of thought, and to the power of psychic correlation.

Differences between unconscious and pre-conscious *forms of ideational presentation* are also of significance in intellectual development. The 'thing' presentations of the unconscious system are naturally less suited to the purposes of conceptual thinking than the word-presentations of the pre-conscious system; and equally naturally the auditory type of pre-conscious thinking is much more elastic than either the visual or the much rarer olfactory type. As can be seen from a study of symbolic thinking, the more primitive the type of presentation employed the more it is subject to unconscious interference. The symbolic thinker is a man of intense conviction but a poor logical thinker. For the same reason primitive types of ideation are suitable only for very early forms of learning: at the later stages of development they obstruct the intellectual faculties. The influence of *phantasy formation* on intellectual development depends mainly on the efficiency of unconscious mechanisms of defence, in particular on the smooth functioning of repression. When these mechanisms operate without friction the creative powers of the intellect are enormously enhanced. Phantasy thinking develops into imaginative work. When however their function is faulty, phantasy formation has a detrimental effect, as is well illustrated by the difference between normal and pathological introversion.

Needless to say each of the *defence-mechanisms* contributes either in a progressive or in an inhibitive sense to intellectual development and to the various abilities and capacities scheduled by the descriptive psychologist. They also influence the *direction* of intellectual activities. As has been noted repression can improve conceptual thinking by eliminating emotional sources of interference, while faulty repression gives rise to constant inhibition of associative thinking. A capacity for free displacement and ready identification increases enormously the rapidity of conceptual thinking, provided always no element of conflict is allowed to obtrude itself. Again, the activity of projection, although at first a source of intellectual inhibition, may end by sharpening the intellectual faculties. And the same can be said for the mechanism of introjection. Provided no major source of conflict arises, introjection contributes considerably to intellectual play, but, should the introjected imagos attract cathexis from repressed impulses, thinking becomes a

medium of expressing conflict and to that extent loses reality value. There is some reason to suppose that projection and introjection influence the direction of intellectual activity in that they focus attention respectively on external and endopsychic perceptions.

The influence on intellectual processes of *later* stages of infantile development depends on the success of the process of *sublimation*. Should this mechanism fail to provide an adequate outlet for frustrated energies, thinking tends to become libidinised and so to function as an instrument of unconscious expression. In particular the hostility and negativistic attitudes aroused by frustration of Oedipus wishes tend to secure outlet in thinking processes and so inhibit their reality value.

Confirmation of the importance of unconscious factors in promoting or retarding intellectual activity can be easily secured by studying the disturbances of psychic perception and correlation to be found, in one form or another, in the various psycho-pathological states. Excluding grosser manifestations such as hallucination and delusion-formation, the influence of anxiety and guilt can be studied in the various forms of acceleration and retardation to be observed in the manic-depressive states. Obsessional thinking throws considerable light on the exploitation of intellectual processes in order to control emotional tensions. Perhaps the most interesting findings are those made in the study of various forms of congenital mental defect. A sharp distinction can be drawn between the manifestations of defect that are due to constitutional factors and those superimposed manifestations that are psychogenic in origin, i.e. are due to the cumulative effect of inhibiting factors. These distinctions have an important bearing on the diagnostic and prognostic value of *intelligence tests* particularly when applied to borderline defect. Already it is recognised that anxiety, negativism and numerous other *affective factors* must be taken into account in assessing the value of mental measurements. But this merely points to the necessity of correcting the whole process of mental measurement for the errors that are inevitable when pre-conscious investigations are carried out without regard to unconscious factors.

*Chapter VI*

## PHASES OF MENTAL DEVELOPMENT

The validity of any psychological system can be fairly assessed by the extent to which it can (a) provide a coherent account of the development of mind and (b) correlate satisfactorily development phases with both normal and abnormal aspects of adult mental function. Having outlined the dynamic, structural and economic aspects of mind we are, therefore, under obligation to put these metapsychological formulations to the empirical test of plausible reconstruction. Before doing so it is desirable to bear the following considerations in mind.

In the first place psycho-analytical reconstructions of phases of mental development fall into two distinct categories. Some are based on actual psycho-analytical observations: others are purely working hypotheses. And since it is not possible to conduct a psycho-analysis until the subject is old enough to understand the meaning of words, this sets a definite limit to reconstructions based on direct psycho-analytical evidence. With the rarest of exceptions outlines of mental development before the age of two and a half years are based on hypothetical reconstruction. It is possible of course to seek for corroborative evidence, by the analysis of dreams, by observing the behaviour of infants and by study of the disintegration products occurring in the deepest mental disorders. Of these methods dream analysis is the only one that can be subjected to scientific control. The others depend solely on interpretations made by the observer and are subject on occasion to gross personal error.

It is safe to say, however, that the truly 'embryonic' phases of mental development run from birth to the age of two and a half. This is borne out mainly by study of mental mechanisms. In most instances analysis of the finished product permits us to postulate, sometimes compels us to postulate primitive stages of it. Hence the terms primary repression, primary projection, primary identification and/or introjection, primary sadism or masochism, primary narcissism and the like. It follows that attempts at hypothetical reconstruction should be subject to almost as severe a test as are the basic concepts on which all reputable psychologies are and must be founded. They should be in the nature of indispensable formulations sparingly stated, conforming to the economy of hypothesis, as amply corroborated as possible, and of proven clinical and theoretical value.

In the second place it cannot be repeated too often that although no psychic event can be understood unless it is analysed and described in

terms of mental structure, dynamics and economy, the mind functions as a whole. Here again the study of mental mechanisms acts as a useful discipline. It enables us to counteract the artificial tendency to isolate mental phenomena. The action of repression clearly points to the fact that mental mechanisms operate in groups. Whether we examine the mind serially or in cross section, it is apparent that they function simultaneously.

Nevertheless the phenomenon of regression, to say nothing of other psycho-biological factors, enables us to postulate some definite stages in development, characterised by specific vicissitudes of instinct, specific developments in ego-structure and specific modes of psychic operation (mechanisms). As has been suggested the *theory of nuclear development* permits us to outline the earlier stages in a more comprehensible order. Regarding the mind as a *whole* we are bound however, to consider also the existence of *different layers of development* each of which has a characteristic total function.

As a matter of fact the subdivision of mind into developmental layers has contributed most to our understanding of both normal and abnormal function. Not only do these subdivisions help us to outline with some precision different types of adult personality but they permit us to classify abnormalities (symptoms in the clinical sense) into three main groups. Mental disorders are liable to develop in later life, first, if as the result of early instinctual stress there has been some *excess* or *deficiency* of the reactions appropriate to any developmental period; second, when in the face of strain the psyche has *regressed* to an earlier, simpler and more primitive developmental level than the appropriate one; and third, when the psyche has made a precocious *advance* to a more developed layer than is appropriate, and has thereby been compelled to muster defence reactions it is incapable of sustaining. Problems of etiology, of differential diagnosis and of prognosis are greatly simplified if the essentials of mental development during the first five or six years of life are properly understood. The detailed classification of mental disorders is also made more intelligible. Many disorders of a transitional type exist, e.g. alcoholism, which cannot be shoe-horned into existing psychiatric classifications; and there are many forms of psychotic breakdown which would be more suitably labelled according to the *level* of regression reached than, as now, by some obvious descriptive feature. Particularly in the psychotic manifestations of later life it is often difficult, using current psychiatric terminology, to apply an accurate diagnostic label to the clinical symptoms. Many middle-age and post climacteric psychoses, for example, would be more suitably described as 'three- to four-year-old regressions' than as melancholias or paraphrenias (see psychoses). As will be seen the psycho-analyst correlates different types of normal and abnormal character formation,

with stages in the infantile development of the libido, with stages of ego - and object-formation, and with a variety of mechanisms appropriate to these different stages. In short it is not too much to say that progress in both normal and abnormal psychology is greatly impeded by neglect of a developmental approach to the problems of classification.

For the sake of convenience in presentation the following reconstruction has been divided into age-periods of one year's duration. This should not be taken to imply any hard and fast line of demarcation between these periods. In any case little is known of the earliest stages. Reconstructions of the first year and a half are extremely hypothetical and, needless to say, considerable differences of opinion arise between psycho-analysts as to their plausibility. Obviously it is easy to underestimate the psychic capacities of the suckling, even easier to read into the reactions of the suckling complexities of psychic activity that are more appropriate to later infancy and childhood, or even to adult life, including, it is well to remember, the adult life and reactions of the observer. In the author's view it is safer to underestimate than to overestimate the early organisation of the psychic. The dramatic difference between on the one hand the *primary processes* that are found to regulate the unconscious system and on the other even the simplest of the *secondary processes* that, following the development of speech and auditory thinking, govern the pre-conscious system, together with the remarkable rigidity of the repression barrier should warn us against postulating too readily the existence of organised functions or systems during the earliest phases.

**FIRST YEAR.** Available evidence suggests that although primitive instincts do not all obtain maximum expression at the same period, they all exist from birth; that mental mechanisms are present as 'tendencies'; and that within a few months primordial memory traces are beginning to be organised in loose and scattered formations, the most important of which record the experiences of gratification and frustration associated with the instincts that dominate the period. Behaviouristic evidence suggests that the most important zonal sources of instinctual excitation are cutaneous, respiratory, oral, gastro-intestinal, urinary, anal, muscular and genital. From this series oral and cutaneous elements emerge as dominant interests and soon the *oral primacy of instinct* is established. Oral interests predominate, in the first place, because they can gratify simultaneously self-preservative needs, libidinal excitations and aggressive tensions, and, in the second, because the maximum frustration falls on the oral group (periodic and/or final weaning). Even so there is a necessary combination of oral and other zonal activities, as for example, the use of the musculature

and of respiratory power in screaming from hunger. Sadistic drives are at first expressed through the general musculature, e.g., kicking and screaming, but an oral-sadistic primacy is established when teething commences, and thereby stimulates a more aggressive attitude to the most primitive part-object, the nipple.

From the affective point of view it should be remembered that the infant is subject to *violent fluctuations of instinct*, in particular oral instincts which it is incapable of mastering through its own unaided efforts, since gratification and denial of instinct at this period depend to a large extent on the activities of (what at first only the observer knows to be) external objects (parents, nurses). The tempo of affective tension and discharge is set by oral experiences; for although the other zones contribute to corporeal pleasure, the maximum satisfaction, and consequently the maximum dissatisfaction ('pain') is registered by the oral zone. The tone of pleasure experiences is probably euphoric and is rapidly reinforced by the narcissistic experience of the ensuing state of sleep. Mental pain is certainly acute and is no doubt almost immediately associated with the reanimation of uncontrolled anxiety, a repetition of the traumatic experience of birth. Primitive mental activities are due to the need to control or reduce the violent (painful) fluctuations in tension.

No doubt all unconscious mechanisms operate in a rudimentary way but it is clear that the first mental activity to function as a defence-mechanism is that of *regression*. Regression is indicated by the infant's periodic retirement to the more complete narcissistic state of sleep. Study of dreams, in particular those occurring in early childhood, suggests that this retirement is sustained by a primitive form of wish-fulfilment, which in turn is due to regression of excitation to the sensory end of the psychic apparatus, giving rise to visual and tactile images of a hallucinatory type. In principle this represents an attempt to recapture pleasure states by the reanimation of their associated images. Next in importance to regression come the tendencies of instinct to *reversal from activity to passivity* and to *reflexion*, i.e., turning in the direction of (what the observer knows to be) the subject. This is reinforced by the amount of primary masochism in the psyche and the infant's discovery of possibilities of auto-erotic gratification. Regression, the discovery of other sources of pleasurable excitation and experience of interrupted sleep prepare the way for primary repression.

None of the mechanisms so far described presupposes or requires any fixed recognition of the distinction between 'self' and 'not-self', a fact which goes far to confirm the assumption that they are truly primary. They can be regarded as *movements of libidinal and aggressive energies (cathexis) between different points in a narcissistic system of organisation, founded on primordial memory traces*. As however the

other mechanisms to be considered involve some distinction between the self and its objects, it is necessary to interpolate here an outline of the structural development of the period.

Needless to say this is of the most primitive order. There is no clear separation of ego and external objects. Distinction is based on the capacity of the infant to distinguish 'pains' that can be avoided by motor flight (withdrawal) and 'pains' that cannot be so avoided – a distinction which incidentally puts a premium on muscular activity. Nevertheless 'reality sense' of a primitive type, i.e. accurate estimation of the relation between instinct needs and the source of their gratification or inhibition – a feat which depends on distinction between different degrees and qualities of pleasure or pain – is present from the beginning; it is periodically interrupted, first by regression to sleep and second by the development of acute emotional crises. Progress in the distinction of subject and object is accelerated by the discovery of auto-erotic zones which are distinguished from external objects by their greater accessibility. The objects discovered are of course (what the observer knows to be) part-objects, e.g. nipple. Incidentally the term 'part-object' which has crept into common analytical use would be better discarded. It is essentially an object's view of an object. The object of an instinct is that on which the instinct is gratified.

To return to early mechanisms, there is little doubt that the tendency to *projection* is characteristic of the mental apparatus from its earliest beginnings. Instinctual stimulation and the pain that follows lack of gratification appear to come 'into the mind', i.e., they are felt as coming from 'without.' Also the regression that follows sleep, leading as it does to a hallucinatory process, produces images which again appear to come from without. Primary projection considered as a defence mechanism is merely an attempt to deal with stress on a hallucinatory level. Actual projection involves some recognition of true external objects. It is an application to waking life of an essentially dream-like process.

Recognition of subject-object relations is also essential to the process of *introjection*, and in fact distinguishes the latter from primary identification. The repetition, both at the breast and through the discovery of auto-erotic substitutes for the breast, of a sucking and swallowing (taking in) pattern is responsible for a characteristic feeling-attitude towards later objects; in the same way vomiting, expulsion of wind and faeces and voiding of urine produces a characteristic feeling-attitude of expulsion towards objects that cause or are held responsible for causing pain, either physical or mental. These activities are not, as is sometimes held, the corporeal prototypes of primary introjection, which are essentially movements of cathexis associated originally with waking and falling asleep respectively. Confusion between sensory



experiences recorded in the mind and subsequent distribution of cathexis between systems of memory traces has given rise to a number of misconceptions as to the structure of the mind in the first year. A small group of observers have gone so far as to postulate a true super-ego formation derived from an Oedipus complex of an oro-phallic type existing as early as the third month of life. This error is due to a lack of understanding of the basic concepts of psycho-analysis, to a confusion, for example, between the process (mechanism) of introjection and the structural alterations in the ego due to introjection that occur at a later period of development. *The concept of a true genital Oedipus situation existing in the first year not only runs counter to the facts of oral primacy but is against all psycho-biological probability.*

Needless to say organisation during the second half or last quarter of the first year is much more extensive than in the first half or first quarter. In fact it would be desirable to have separate reconstructions for each quarter. It would be idle to pretend, however, that in the present state of our knowledge we are in a position to do so. The same reservation applies to any attempt to make correlations between hypothetical reconstructions of the first year and clinical observations of adult mental disorder. These are almost entirely speculative. For example when we say that the external world, in so far as it is recognised by the infant, is experienced as an organ contributing, as the case may be, painful or pleasurable stimuli, we may hazard the guess that some echo of this state of affairs is to be found in the apprehensions of disaster and cosmic catastrophe appearing in later neurotic and psychotic manifestations. The sense of disaster is a sample repetition of actual (emotional) disasters experienced by the infant. It is projected on to the external world because the infant once confused the relation of inward states to outward events. And it is cosmic because originally the organ gratifying (or frustrating) infantile needs is for the time being the whole external world. Plausible as they are, we are unable to prove these assertions and must be ready to concede that the patient's fear of cosmic catastrophe can be derived also from other and later elements, such for example, as fear of loss of love, intense hatred of both father and mother imago and unconscious fear of castration.

With this reservation we may assume that excessive disturbance during the first year contributes extensively to all psychotic types of reaction particularly to the disintegrated phases of advanced psychosis. When studying variations in the clinical manifestations of schizophrenia, it is well to remember that although individual variations in the developmental processes are of importance, constitutional factors are of the utmost significance. In fact it is during the first two years that they exert their maximum influence. To take oral impulses alone, it is well recognised that babies vary considerably in their reaction

types. Some are lethargic and slow in sucking, falling quickly into immobility; others react in a violent and hostile manner. And there are numerous intermediate types of reaction, anxious, restless, querulous, dissatisfied, each one of which must influence in a characteristic way the course of development during the first year. Similar constitutional variations affect the development of other infantile components in the first year, and give rise to specific types of reaction. We may surmise that the various forms of schizophrenia can be related to some of these temperamental divisions. Similarly paranoia and manic-depressive states probably owe some of their emotional and delusional characteristics to reactivation of patterns laid down during this period. Here again it would be a mistake to regard these conditions simply as regressions to the period. Obviously the more elaborate form of ego-development found in paranoia and manic-depression suggests that the ultimate breakdown must be attributed to other and later developmental factors. It is significant, however, that in schizophrenia there is a wider scatter of instinctual disorder than in paranoia and manic-depression where, on the whole, anal and oral sadistic factors respectively predominate. Incidentally, it has sometimes been suggested that the psychological factors in epilepsy can be traced back to this stage. As will be seen later, however, the epileptic seizure involves simultaneous disturbance of a number of developmental layers. The influence of the first year on convulsive mechanisms is limited to 'functional' discharges of psychic tension having no specific content. (See Psychosomatic and Allied Disorders). In certain types of alcoholism, oral sadistic conflict is so intense that we are entitled to conclude that experiences in the first year of life have predisposed to the election of this form of disorder.

On the whole it would seem desirable to describe development during this year as *predisposing* to the choice of different disorders, rather than forming fixation points to which the mind actually regresses. This is certainly true of the psycho-neuroses. The readiness of the infant to fall into cathartic states discharging anxiety is easy to understand. The infant not only suffers very considerably from floating anxiety but has an extraordinary sensitiveness to it (anxiety-readiness). Unusual incapacity to master anxiety unquestionably contributes to the various localisations of anxiety found in the simple phobias and states of conversion.

**SECOND YEAR.** In general the infant's mind is still dominated by the need to master or avoid the discomforts arising from frustration of primitive impulse. The oral phase of development gradually closes and with it goes the urgency of the need to find substitute oral gratifications. Actual breast or bottle weaning may have been completed earlier but during the first half of the second year a good deal of energy is devoted

to mastering delayed oral-sadistic reactions to the final loss of earlier oral satisfactions. As the oral phase closes the primacy of impulse is taken over by the urethral and anal group. In the earlier half of the period control of urethral and anal activities is far from complete, but during the second half it is rapidly established, at the cost, however, of considerable hatred against the persons responsible for interference with these functions. Conflict over oral sadism is thus replaced by conflict over excretory sadism. Residual oral-sadism tends to reinforce the intensity of anal-and urethral-sadism. Infantile genital impulses increase in intensity and give rise to early forms of genital masturbation.

Affects still fluctuate violently and the mechanisms of regression, reversal, repression, projection and introjection are still dominant although in their more primitive forms. Rapid increase in motor co-ordination and consequently in motor play together with increased exploration of auto-erotic outlets hasten the process of distinguishing subject-object relations. And speech-formation, though still rudimentary, permits a rapid expansion of unconscious phantasy and conscious thinking. Both forms of ideational activity are, however, still predominantly corporeal in type, and expressed in relatively unco-ordinated 'thing presentations'. Visual thinking only gradually gives place to auditory thinking. For the first time word stimuli acquire true meaning.

Distinction between subject and object in its turn promotes the development of the ego; and the summation of dynamic processes of introjection begins to manifest itself in the structure of the ego. The abandonment of earlier object drives and the psychic introjection of increasingly organised object imagos leads to the formation of early nuclei of the super-ego. This probably takes place about the age of eighteen months. Although this view is controversial it seems justifiable to describe these nuclei as primitive anal-sadistic super-ego deposits.

With the development of primitive forms of speech and rudimentary conceptual thinking, the infant may be said to have developed an egoistic 'point-of-view'. As, however, the expansion of the pre-conscious system consequent on exercising some power of speech gradually enables actual repression to operate, we must distinguish between reality thinking and phantasy thinking. And as the latter is subject to a good deal of repression, we must distinguish also between a more or less organised conscious point-of-view and a series of unconscious phantasy systems which are not subject to any logical process or reality correction. Generally speaking, the infant's view of the external world is animistic, a conclusion which is based on the study of primitive phobias (e.g. of noise, darkness, strangers, being alone, etc.). Inanimate objects are treated as if they were alive and potentially malignant, a state of affairs in which the operation of displacement becomes increasingly manifest. Under the influence of gastro-intestinal experience

and phantasy the infant regards his corporeal inner world as vulnerable and frequently inhabited by evil and pain-causing objects. These phantasy products should not be confused with the process of psychic introjection of objects.

At the same time complementary phantasies develop as a result of corporeal pleasure experiences, in which case the imaginary objects are regarded as 'good'. In the early part of the period faeces (and of course any other substance that can be produced from within the body) have the status of instinctual objects. This can be clearly detected in the body play of infants whose excretory processes are not wilfully interfered with by parents. During the second part of the period a change in attitude may occur spontaneously. Some primitive forms of reaction-formation develop and, particularly in the case of cleanliness, this seems to be accelerated by a kind of phobic reaction. Fear of dirt and forms of disgust are difficult to appraise since as a result partly of mimicry which promotes identification and partly of fear of loss of love of parental mentors, the child may 'take over' precociously reactions of an excessive type. All these observations go to show that a primitive form of organised super-ego activity has in fact been established usually in the second half of the second year. Aided by the more co-ordinated forms of play, these displacements and reaction-formations open up channels for sublimation.

We must be careful, however, not to exaggerate the state of organisation of introjective defences at this period. Although primitive anxiety forms are beginning to give place to some extent to guilt forms, implying endopsychic sources of danger, guilt mechanisms do not act independently and spontaneously. The child is still under constant surveillance and rapidly expanding his capacities to identify with parental and other familial figures. Guilt is still at the stage of primitive social anxiety activated readily by the *presence* of the disapproving object. This is borne out by the fact that primitive forms of phobia formulation still persist, and that when genital interests increase, as they do during the second year, the anxiety phantasies they provoke suggest the idea of deprivation of the penis at the hands of an external figure. In other words there is a tendency to identify faeces and penis and to react to ideas of genital injury as if they implied anal loss.

Clinical correlations can be established with more confidence for the second year than for the first. The period is marked by the laying down of patterns many of which are reactivated in psychotic states. The persistence of feeding difficulties, and the concentration of interest in bowel, bladder and intestinal functions, together with the hostilities and anxieties aroused by this libidinal concentration predispose not only to psychotic hypochondriasis but to the later tendency to form hysterical conversions. It also provides the background for borderline

or 'transitional' states. Schizoid, antisocial and asocial reactions have their origins in this period, as have the graver forms of alcoholism and drug addictions. This is due largely to the overlap or confluence of oral-sadistic and anal-sadistic reactions. The more persecutory the type of addiction the closer it is related to anal-sadistic anxieties. In depressed types of addiction oral elements predominate. Early reaction-formations prepare the way for later obsessional ritual. Indeed the child may already have exhibited a tendency to ritualistic repetitions of behaviour of an obsessional type. Inhibitions of play are common and contribute to later forms of selective defect in learning.

When estimating the influence of the period on normal adult function two factors should be taken into account. First, although the 'point-of-view' of the child is still largely animistic, the severity of its anxieties is to a certain extent modified by the development of habit formations which are essentially reaction defences. In the second place, animistic anxieties are obscured by the rapid development of pre-conscious systems of thinking and by much more intimate contact with familial and other 'objects'. It is during this period that the child begins to develop 'character' and many of the normal and abnormal character traits of adults are developed from formations established during this period.

**THIRD YEAR.** This is a fateful period in the development of the child's mind, a time during which the passage has to be made from primitive and loosely organised function to a state of psychic organisation, which, although by no means stable, can be depended on to meet current stresses. It is a time when the mind, having liquidated some of its earlier disintegrating problems, proceeds with the work of consolidation and synthesis. Much depends on the success of these psychic efforts, for within a comparatively short time, in some cases towards the end of the same year, but certainly in the fourth year, the child will be faced with the greatest emotional crisis of its life.

During the third year the primacy of excretory components of sexuality is gradually abandoned. Defences against anal, urethral and other body phantasies are consolidated. These take the form mainly of displacements, reaction-formations and substitute-formations, a fact which can be amply confirmed by study of the child's play. These defences are strongly reinforced by the expansion of the pre-conscious system which follows increased capacity for verbal expression and conceptual thinking. Nevertheless the influence of the anal phase still prevails and the role of sexuality can still be more readily thought of in terms of activity and passivity than of masculinity and femininity. On the other hand the infantile genital impulses steadily increase and in some children, who either because of constitutional factors or because of traumatic experiences, have made a precocious advance to the genital

phase, may actually reach their peak by the end of the year. The increase in genital interest signalises the commencement of the true genital Oedipus situation, for although it is now the custom to talk of pre-genital phases as part of a total Oedipus situation, the genital phase of it is by far the most far-reaching in its effects. In less precocious cases, however, the general tendency of the period is to identify with the parent of the opposite sex and in this way early forms of homosexual attachment make their appearance.

As a result partly of repression of anal-sadistic impulses and partly of the increasing activity of reaction-formation and sublimation, the instinctual crises of the child are neither so acute nor so extensive in their range; hence emotions are much more controlled. On the other hand the hostility aroused by anal interference makes the child's feeling towards objects extremely ambivalent. Object relations are much more complete and the child is capable of making more satisfactory identifications. Introjection processes are still active, and since in the main these are concerned with objects of anal-sadistic interest, they contribute to the formation of super-ego components which are characterised by severity of censorship. Many observers take the view that true super-ego formation commences only at the end of this period, when genital elements begin to preponderate.

The numerous and varied abnormalities that may be traced back to the third year are in keeping with the complexity of the mind at that time. A great deal depends on whether the child, having weathered the last of the pregenital phases, is plunged too suddenly or too passionately into its final battle with infantile love and hate; namely, the positive and negative genital Oedipus conflict. Should this occur, either the ego develops in an inhibited fashion or regression takes place to a purely anal-sadistic type of organisation. Severe personality disorders and conditions such as alcoholism, sexual inversion and delinquency can be traced to this period. The neurotic symptoms corresponding to this phase are mostly of the obsessional type, mixed with a certain amount of phobia formation. The phobias are, however, no longer of a psychotic type but represent a defence against precocious genital sexuality and are therefore early hysterias. Various inhibitions can be traced to this period, in particular inhibitions of learning and of the intellectual capacity. Social anxiety appears, confined mostly to the family or immediate extra-familial environment, a pattern which is repeated later on in more adult forms.

Developments during the third year have an important influence on the formation of character. It should be remembered, however, that the change-over from primitive to comparatively civilised reactions effected during the period is bound to be reflected in adult character forms and so give a somewhat confused and contradictory impression.

There is a mixture of primitive and rather aggressive patterns with more inhibited types of character reaction, and, as has been suggested, a good deal of normal ambivalence is expressed in the forms of character reaction. For this reason the period provides a rich field of research into abnormalities of character, in particular the so-called psychopathic types.

FOURTH TO SIXTH YEARS. Although some children pass through the climax of genital interests in the third year, these are more often spread over the fourth and fifth years and practically disappear by the sixth year. *This is the classical Oedipus phase.* Aggressive impulses are deflected through genital systems and produce the classical forms of infantile sexual rivalry. Innumerable forms of unconscious genital anxiety (castration and mutilation fears) appear. These constitute the main etiological factors for both conversion and anxiety hysteria. By far the greatest number of cases combine true hysterical formation with social anxieties and inhibitions. Various forms of psycho-sexual inhibition (impotence, frigidity, etc), can also be traced to this period of development. Seductions commonly occur at the earlier part of the period but in the later stages infantile masturbatory activities begin to diminish. Needless to say, a great number of marital difficulties depend on patterns laid down during this phase. These are due either to the existence of genital anxiety and guilt or to an unconscious regression to homosexual attitudes characteristic of the third year.

The unconscious mechanisms characteristic of the period are repression, displacement and inhibition. As the infantile incestuous drives towards parental objects reach their climax, the processes of introjection complete the work of super-ego formation. Thereafter more sophisticated identifications with objects are set up and contribute some of the more easily recognised and superficial features of both ego and super-ego. There is a closer approximation between the ideals-of-the-ego and super-ego standards. It should be added that these identifications not only hasten the processes of inhibition but are largely responsible for the nature of adult object-choice.

It will be seen that although *ego-synthesis* is a continuous process occurring throughout all infantile development, a considerable degree of *ego—super-ego synthesis* occurs towards the end of this final period, i.e. the total ego having passed from an unformed state into one of acute differentiation begins to knit together and conceal its dissociations. But this synthesis is never complete. Throughout life instinctual problems tend to bring out the division between ego and super-ego. This is by no means unhealthy. On the contrary, complete absence of conscious conflict is sometimes a sign of mental regression.

LATENCY PERIOD. The period which falls between the final abandonment of infantile genital sexuality and the onset of puberty has been desig-

nated the *latency period*. This varies in duration but as a rule runs from the sixth to the eleventh year. In some cases the duration of infantile sexuality is abnormally prolonged, and, should pubertal manifestations make a precocious appearance, there may be no sign of interruption in sexual development. Nevertheless even in such cases, the overt manifestations have already acquired a symptomatic (regressive) rather than a developmental significance. The habit of masturbation which sometimes persists throughout the period is already of an obsessional type. No changes in the accompanying (conscious or unconscious) phantasies can be observed until puberty develops. In any case there is always a quantitative reduction in the amount of psycho-sexual stimulation.

The latency period is essentially a period of psychic consolidation. The psyche has a respite from infantile urges, a few years in which to establish defences which will be severely tested at the onset of puberty. Indeed it would be unreasonable to suppose that the emotional turmoil of the preceding years can be suddenly and successfully controlled. In this sense the duration of latency is a rough measure of the time required to 'get over' the cumulative frustrations of early childhood and to perfect the mechanisms of defence. Whilst, therefore, no new developmental activities occur, existing defences are co-ordinated and extended. The outlets for sublimated energies multiply; new object relations of an aim-inhibited type are established; extra-familial group formations begin to expand the individual's social sense and capacity. The child in short becomes more and more like an adult but of course an inhibited and still dependent adult.

It would be a mistake to suppose, however, that development proceeds smoothly during latency. The increasing freedom of the child provides a number of situations favourable to the break through of infantile reactions that have been in their time unduly charged. A number of these take an anti-social form. It is therefore safe to say that the experiences of the latency period contribute very largely to the smoothness of social adaptation in later life. Severe social maladaptations are aggravated by traumatic experiences occurring during the period.

**LATER DEVELOPMENTS.** With the onset of puberty the differences between the child and the adult are either gradually or rapidly obliterated. Under the impact of the new and powerful sexual excitations of adolescence, the mind may shew signs of faltering and regression. For this reason a number of transient regressional manifestations, e.g. overt homosexuality or anti-social conduct can be discounted. Within a year or two the average adolescent has adapted with reasonable success to the stimulations of adult instinct and to the new conditions imposed on him by environment. Aim-inhibited relations continue to expand and the search for adult sexual objects begins. This is at first character-



ised by fleeting and mobile attachments which are nevertheless governed by a high degree of idealisation of the object. Erotic urges are mostly satisfied by masturbation; such erotic object relations as exist tend to be directed to objects that are either idealised or positively regarded as 'inferior'. This dichotomy between erotic and aim-inhibited attachments, although in a clinical sense normal enough, can be traced back to an original infantile conflict between repressed and aim-inhibited urges towards parents. In short, apart from the change in sexual aim and object due to the development of adult impulses, no new factors in mental development can be detected. Abnormalities or deviations in development can be explained adequately by regression to earlier forms of organisation. On the whole, therefore, although adolescence provides impetus in the direction of adult function, the clinical significance of puberty lies in the amount of regression set up during the period. In this narrower sense pubertal experience can be regarded as a *precipitating factor* leading to characteristic adolescent disorders often of a traumatic type.

The same can be said of the various 'critical periods' that arise in the course of adult instinctual experience. Although the endocrinologist is concerned with the bio-chemical basis of sexual changes, the psychologist is interested in fluctuations of psychic energy and in the reactions these vicissitudes produce. From the point of view of mental function he is concerned to know how far such changes promote adaptation or how far they function as precipitating factors leading to regression and symptom-formation. He is also aware that even in the absence of any verifiable bio-chemical changes, the individual reacts at certain periods of his life in a manner that suggest unconscious fear of loss or injury of his instinctual capacities. This is particularly notable in men who have reached the age of forty. From the psycho-pathological point of view, the significance of post-pubertal crises turns on both quantitative and qualitative factors, but it can be most conveniently estimated in terms of precipitating factors.

## Chapter VII

## DREAMS AND SYMPTOMATIC ACTS

DREAMS. With the best will in the world the student of mental disorders finds his path beset with peculiar difficulties. On the one hand he is confronted with symptoms that are apparently incomprehensible, irrational and absurd. And unless he is going to content himself with purely rule of thumb methods of clinical diagnosis, he must make shift to decipher their meaning. Indeed without some understanding of the meaning of symptoms he cannot be expected to appreciate the part they play in the patient's mental economy. And this in turn means that he cannot reasonably venture a prognosis of the case. On the other hand the most detailed descriptions of the mental apparatus and the most elaborate reconstructions of mental development are at first calculated to bewilder rather than to enlighten him. For the structures and functions described are for the most part as unfamiliar and peculiar as the symptoms they are intended ultimately to explain. The main source of the difficulty lies in the fact that the mental functions with which the student is familiar are those which govern the pre-conscious system of his mind. His first task therefore must be to become conversant with those primary processes which are characteristic of the true unconscious. Some progress in this direction can be achieved by studying the formation of *dreams*. It was an old saying of Freud's that interpretation of dreams constitutes the *via regia* to knowledge of the unconscious in mental life.

But although study of dream life paves the way to understanding, it does not automatically bestow on the student a capacity to interpret dreams. Still less does a description of the processes of dream formation communicate this capacity. In the absence of a full technical training therefore the benefits of studying dream life are strictly limited. It affords an opportunity of observing almost *in statu nascendi* the end products that are formed when unconscious and preconscious systems secure a marginal amount of intercommunication and it establishes the conditions under which such communication takes place. Moreover the interaction of various mental mechanisms can be studied and the divisions of the ego more closely observed. It is possible also to watch the combined action of various layers of psychic development each of which makes its contribution to the finished dream product. Finally *we can observe in the formation of a dream the same set of processes which, acting over prolonged periods, is responsible for the formation of symptoms.*

The study of dreams therefore helps to correct a number of false impressions that might arise from a purely theoretical approach to psychic function, e.g. the view that each unconscious mechanism works independently of the others, or again that different parts of the ego are in a state of permanent isolation. On the contrary one of the most important functions of the ego is a 'synthetic' function. Unless a state of active conflict exists the different parts of the ego tend to merge with one another, and however exaggerated its activity may be no mechanism works alone. This synthetic function of the ego though obviously of great service to the individual can also work against his interests, as when his ego comes to terms with a neurotic system and seeks to encapsulate it.

The easiest approach to the study of dreams is to consider first of all the regressional functions of sleep and then to examine some of the simpler forms of dream produced by young children. It is clear that the aim of regression is to reduce the stimulations that excite the mental apparatus to a level at which sleep is possible. And it is equally clear that even in small children the manoeuvre is not uniformly successful as the common occurrence of night-terrors plainly indicates. The dream is itself a proof that psychical disturbances develop during sleep and that they rise almost to the threshold of consciousness; in other words, they operate in a direction opposite to that of regression. When however we study the dreams related by small children, we find that they represent quite simply the gratification of wishes that are more or less congruous with the period of mental development; as, for instance, dreams of eating unlimited quantities of chocolate or of holding in the hands huge pieces of money. It is not difficult to surmise that these simple wish-fulfilments serve, temporarily, the purpose of withstanding tensions that would otherwise be felt as painful frustrations. It is a characteristic of mental life that when an individual suffers frustration, he tends to regress to an earlier level at which frustration can, however briefly, be denied. That the wish fulfilment in a dream acts in the interests of regression leads naturally to the assumption that *the primary function of the dream is to preserve sleep*, or to prevent waking up. The fact that it does not always perform this function successfully is easily explained.

Confirmation of the validity of this hypothesis can be secured by observing the way in which disturbing sensory stimuli are woven into the texture of dreams; as in the case where the noise of an alarm clock becomes a natural part of a dream. The sound is interpreted by the dream process as *anything else but* a noise intended to wake the sleeper up. In other words it is explained away. In certain cases the dreamer may actually wake up, walk across the room, turn off the alarm, go back to bed, fall asleep, make fresh dream interpretations of the memory of the

alarm and ultimately wake up with no recollection of the intervening waking activity.

Study of insomnia and of the different forms of waking up shews that the problem can also be approached from the opposite (instinctual) end of the mental apparatus. It is not difficult to establish that internal (endopsychic) excitation works against the regression of sleep, as witness the difficulty in falling asleep immediately after strenuous mental effort, after a quarrel, or even a game of chess. And it is a natural assumption that the stimulations of instinct are likewise woven into the texture of dreams and thereby, for a time at any rate, explained away. As a matter of fact of the two sources of disturbance, viz. the internal (instinctual) is far more powerful and continuous than the external (perceptual) source. For although the sensory systems and perceptual consciousness are blanketed by sleep it is not possible to stifle the Id.

Nevertheless the more 'natural' approach to dream phenomena is from the surface inwards. Hence we may begin by examining the *manifest content* of the dream, in other words, the dream narrative. Now in contrast to many of the dreams of small children, the dreams of adults generally give the impression of being a jumble of inconsequent or incongruous elements (images, thought, feelings, utterances and actions), a sort of theatrical representation without rhyme or reason. Practice in sorting out this content soon shews however that it is capable of orderly classification. Thus it is not difficult to distinguish the existence of a variety of *recent impressions*. Some of these are apparently of a trivial order, but, using the technique of 'free-association', it is not hard to establish that they are closely connected with events of emotional significance, are in fact displaced derivatives of unsolved emotional problems. These *day-remainders* refer as a rule to events occurring in the previous waking interval. They can be studied in an exaggerated form in mild cases of insomnia, when after an interval of sleep the individual wakes up and finds his mind turning over some incident of the day before, the emotional tone of which is disagreeable. But in this case the events have acquired additional significance during the intervening period of sleep; they have been manipulated by unconscious forces and now represent deeper conflicts. Hence their greater intensity and persistence.

The manifest content also includes a number of *memories* particularly from the different phases of childhood. These are sometimes rendered with circumstantiality but in many instances only a detail of the memory system is represented, e.g., the placing of a window or door which can be 'dated' with relatively slight associative effort and recognised as belonging to a particular period of childhood experience.

In some cases recent impressions and memory pictures are woven together in such a way as to give the manifest content an appearance of

logical form, but more often the manifest content includes a number of presentations that are entirely inconsequent, surprising, peculiar, bizarre and apparently incomprehensible. Some of these *distortion products* can be rendered more intelligible by associative thinking; others again are apparently refractory even to associative methods. And at this point it becomes obvious that even with the help of conscious memory work, no further progress can be made in elucidating the dream problem. The observer is in the position of a clinician who has established the precipitating factors in a neurosis, has collected all available information as to its date of onset, development and final symptomatic form, has listened to all the rational explanations offered by the patient to account even for the most irrational symptoms, but is still unable to make head or tail of the disorder.

This fact alone would justify the assumption that the processes responsible for dream formation are themselves unconscious, and that only by applying techniques which give access to the unconscious system of the mind can we expect to discover the meaning of a dream. Some evidence in favour of this assumption can be secured by studying the changes that affect the manifest content in the day following the dream. It is not hard to shew not only that the power of conscious recall of dreams diminishes rapidly on waking, but that deliberate effort to recall a dream often accelerates the process of forgetting. Even those dreams which on waking have been remembered without difficulty usually disappear beyond recall after a few hours. Moreover the experiment of making a written record of a dream which is subsequently checked by oral records taken at intervals throughout the next day shews that the manifest content is subject to falsification, elision and fabrication before it is forgotten. On the other hand during the narration of a dream a number of fragments may come to light that were not recalled on waking. And it is a common experience that on waking from anxiety dreams, the dreamer may be compelled to make vigorous attempts to reach full consciousness in order to avoid 'falling back' into the dream state. All of these observations suggest that behind the manifest content, there must exist some *latent content* which is highly charged with instinctual energy, subject to active obliterative processes, and capable of exercising a pull (extraction) on more superficial mental activities. The resemblance to the activities of repression is in fact too strong to be ignored.

Further confirmation of the hypothesis can be gained by submitting the apparently incomprehensible or trivial elements of the manifest content to close examination by means of the *technique of free association*. This reveals the existence of a number of mechanisms which are characteristic of unconscious function. The first of these goes by the name of *condensation*, implying that a single element of the manifest

content represents several latent thoughts. In condensation there is little regard for logical composition; or rather the logic is the logic of the unconscious system whereby associative links are determined by a fundamental element of interest which they have in common. For example the persons appearing in dreams are usually composite figures, combining the characteristics of a number of different individuals; or alternatively a number of persons can be represented by one characteristic they have in common. As a rule the characteristic is apparently trivial, for example, the colour of hair, but on closer examination of the *affective* associations it becomes clear that the dynamic element in common is an emotional situation, different aspects of which are illustrated in the personal relation of the dreamer to the figures that are condensed. The formation of neologisms in dreams and use of portmanteau words is due to the same process.

Next in importance to condensation comes the mechanism of *displacement* by means of which a highly significant idea belonging to the latent content is represented by an apparently insignificant idea or detail in the manifest content; or an important affect becomes attached to an unimportant idea. The dreamer may, for example, observe a slight scratch on the back of a chair, make feverish attempts to remove it and be overcome by a sense of hopelessness and dread. Of the same nature is the process of *allusion* which plays such a large part in dream-work. Many of the associative links are, from the logical point of view, of the most primitive order; others again allow free play to the technique of *dream-wit*. So-called klang-associations lead to the formation of *dream-puns*, *double meanings* and other forms of *word play*. Representation of the whole by a part or of a part by the whole is common.

To these two mechanisms, condensation and displacement, can be attributed the characteristics of *over-determination* and *distortion* that give the manifest content of a dream its peculiar and apparently incomprehensible nature. Their combined action accounts also for the number of trivial details with which the finished dream is studded; these are essential to the smooth working of both mechanisms. Moreover the fact that the action of these mechanisms can be reversed only by laborious and prolonged mental effort indicates that the very incomprehensibility of the manifest dream is brought about by an active *defensive* system operating unconsciously. To this defensive system Freud originally gave the name of the *dream-censorship*, a function which was later ascribed to the unconscious super-ego.

The operation of a third mechanism can be inferred from the fact that the manifest content of the dream consists for the most part of *visual presentations*. The childhood memories that are recovered in dreams are represented as it were in action, as are various phantasies contributed from different periods of infantile life. The arrangement of

these forms of representation is called *dramatisation*. It is one of the most striking manifestations of the general tendency to *regression* that sets the dream process in action. More complicated thought forms are broken up into their perceptual constituents, and so deprived of their logical relations. In this way the mind returns to its earliest forms of activity in which a delaying process of *hallucinatory wish fulfilment* holds up the painful state of frustration which would otherwise disturb sleep.

All of these processes of indirect representation are characterised by their lability. But there is one form in which primitive ideas obtain representation which is fixed and irreversible. The process is known as *symbol-formation*. In symbolic representation, a concrete idea, usually a visual presentation, is used as a substitute for another idea which belongs to the unconscious. It is a kind of fixed identification based on the existence of an element which the unconscious idea and its symbol have in common. Although this primitive form of thinking has in the racial sense, an evolutionary basis, the re-creation of symbols is the result of early mental functioning in the individual. Once formed symbols are, however, independent of individual factors. This quality of rigidity gives some hint of the archaic nature of symbolism which is in all probability a derivative of the phase of primary identification (q.v.). In this connection it is significant to note that the cathexis of symbolic presentations is unsublimated. As might be expected symbols represent almost exclusively the love and hate relations of the infant to the (family) objects of its instincts. These are expressed in the simplest corporeal terms, or, more accurately, in terms not only of the bodily organs and activities that bridge the gulf between the infant and its parents, but also of the body-wishes and phantasies that are never gratified. Birth, baby-making, sexual intercourse and (indirectly through symbols of mutilation) death, are the main themes of this primitive thought-system. This accounts for the variety of phallic and other genital symbols. Common examples of phallic symbolism are: serpent, eye, tooth, knife; female genitals are symbolised by house, bag, purse; luggage represents male genitals in general. Some symbols are bisexual, spider, shoe, etc. Breasts, nipples are symbolised by fruit; the abdomen by a box or chest; babies by insects and small animals; birth by coming out of water; faeces by money or snow; parturition by losing a tooth. Ideas of genital injury are also symbolised in the male by loss of a tooth. Injury of the female genital is represented by cutting or stabbing. Although symbols exist in endless variety, the subject matter of symbolic thinking is limited to a few dozen primitive corporeal situations and their associated phantasies. Symbols are refractory to associative thinking but their validity is sometimes confirmed when the sleeper happens to wake up from a dream in a state of erotic excitation

and is able to detect the relation between a particular symbol and the part of the body disturbed. Otherwise it is not possible for the ordinary observer to distinguish between symbols and other presentations by study of the manifest content alone.

We are now in a position to summarise the structure and function of dream formations. The principal function of dream activity is to preserve sleep. The most constant cause of disturbed sleep is the increasing tension of unconscious (repressed) excitations. The mental apparatus seeks to satisfy the disturbing wishes but because of the complete inhibition of motor discharge is compelled to use a regressive sensorial form of presentation. Owing to the action of the dream censorship this gratification must however be disguised. Otherwise the affect produced by the hallucinatory gratification of unmodified repressed wishes would waken the individual up. The apparent absurdity of the manifest content is the result of a compromise between the repressed and the repressing forces; in other words, the manifest content is an allegorical expression of unconscious latent content, rendered still more obscure or even absurd by various forms of distortion. The building up of this manifest content out of the latent content constitutes the *dream-work* proper. It is however a mere translation or transformation, a kind of coding in which the repressed wish and the counterwishes aroused by the need to sleep are equally represented.

The discovery that the dream-work does not itself involve intellectual activity, that whatever appears to represent intellectual work in the manifest content has been taken over from the latent content is one that usually provokes considerable scepticism. This is due to a misunderstanding of the function of the dream. The dynamic situation behind the dream as in the case of the neurotic symptom is one of conflict and as in the case of symptom-formation the mechanisms which operate are themselves unconscious. Dream-work is no more intellectual than the processes whereby unconscious wishes and unconscious defences obtain expression in a neurotic symptom. There is however a stage subsequent to that of dream-work and prior to awakening when near-conscious processes begin to play an important role. The mechanism concerned is called *secondary elaboration*. Its main function is to bring the distorted products of dream-work more into harmony with the standards of (pre)-conscious thinking; in simpler words, to 'make sense' of them. But although secondary elaboration sometimes succeeds in giving a consequent air to the dream, it also serves the purpose of defence; for the more reasonable a dream appears the more effectively its meaning is concealed (see Rationalisation). *In other words secondary elaboration is a spontaneous but wholly inaccurate dream interpretation.*



*Dream-Formation and Symptom-Formation.* The resemblances between dreams and symptoms are manifold. Indeed it is sometimes said that the dream of the normal person constitutes 'normal neuroses' as distinct from 'symptom-neuroses'. Both are apparently absurd yet both have a hidden and consequent meaning. The defensive mechanisms are the same in both instances and in both dream and symptom the conflict is aroused by unconscious impulses. Both represent imaginary gratifications of these unconscious wishes and in both cases an element of compromise between the repressed and the repressive forces is present. As a rule there is more secondary elaboration in dreams although many obsessional states exploit this mechanism to an outstanding degree. Regression, theatrical representation of infantile content and symbolism are found in both. Dreams and symptoms both tend to be forgotten and many inaccuracies creep into the recital of their course or history. Even closer are the clinical resemblances. In hysteria the environment is frequently reacted to as it would be in a dream; and many twilight states, dream states, somnambulisms and states of exaltation are easy to understand if regarded as dream reactions occurring in waking life having as their aim the gratification of unconscious wishes. Whereas hallucinatory mechanisms are normal dream procedures, the intrusion of dream mechanisms in waking life usually stops short of hallucination. True hallucination is, however, a common manifestation of psychotic breakdown. In conversion hysteria free use is made of body symbolism to represent infantile ideas. *Dream pairs* in which the first fragment represents the gratification of unconscious wishes and the second their rejection have obvious resemblances to the diphasic structure of obsessional neuroses (q.v.). The *precipitating factor* in symptom formation has roughly the same dynamic significance as the *day-remainders* which evoke dreams. The affect of both dreams and symptoms is congruous with the nature of the unconscious wishes, i.e. however unrealistic they may appear they are always appropriate to the intrapsychic situation.

In the hands of those who are familiar with the meaning of dreams and with the language of symbolism, study of manifest content is of service in diagnosis and to a certain extent in prognosis. This applies mostly to the content of recurring dreams or of dreams accompanied by violent affect. There are many typical dreams and easily translated symbols which give a clue to the central anxieties and conflicts of the individual. Each stage of development contributes its quota to the more stereotyped content of dreams. The recurrence of situations or symbols of sexual mutilation, for example, gives a clue to the essentially neurotic nature of the symptoms in cases where the diagnosis lies between hysteria and deeper forms of instinctual disorder, such as depression. Similarly with pregnancy symbols. Active and passive homosexual

dreams refer to an earlier phase as do anal-sadistic dreams. Dreams indicating strong unconscious guilt or dramatising persecutory situations are of service in the prognosis of obsessional states, alcoholism and early psychotic conditions. Tension dreams are particularly significant in cases where suicidal tendencies are suspected. Dreams are also of service in indicating the general state of integration of the ego. In the various representations of dream figures, the dreamer can dramatise the state of dissociation of his own ego. Hence it is possible to take a rough measure of the degree of endopsychic conflict, a factor of some significance in arriving at a prognosis or estimating the desirability of recommending treatment.

### SYMPTOMATIC ACTS

Next to the observation of dreams the most useful approach to the problem of symptom-formation lies through the study of those minor disturbances of mental function which can be conveniently, though not quite accurately, described under the heading of *symptomatic acts, errors and lapses*. Freud first drew attention to these manifestations in a treatise aptly entitled the *Psychopathology of Everyday Life*. To those who are inclined to measure abnormality solely in terms of major symptom-formations, it may come as a shock to realise that the so-called 'normal' function of waking life is constantly interrupted by minor crises, or, more accurately, by regressions due to current unconscious conflicts. These 'miniature symptoms' do not receive the attention they merit largely because they are transient in nature. No sooner does the individual observe that he has suffered a lapse of memory or made a slip of the tongue, than he is able to correct the error in function. This power of recovery enables a distinction to be drawn between the miniature symptom and the classical symptoms of the neuroses and psychoses, e.g., the amnesias of hysteria or psychotic disturbances of reality sense, over which the conscious ego has no control. Nevertheless from the functional and clinical point of view a great deal of useful information can be gathered from study of errors in perception, lapses of memory, slips of the tongue and pen, mistakes, stereotyped habits of an apparently trivial nature, and other minor disorders with which the waking life of the average individual is so generously studded.

From the metapsychological point of view it is convenient to subdivide these manifestations in accordance with the particular mental system or function affected. In some instances only the functions of perception and recall are affected, in others there is some interference with ideational expression, verbal or written, and in others again intended actions are either distorted or are replaced by new and entirely in-

appropriate actions. To these groupings can be added yet another in which no special interference with an existing function occurs. It includes a variety of simple or complex actions having apparently no significance, purpose or logical connection with everyday life. Although it was to this last group that Freud gave the name of *symptomatic acts*, it is convenient to apply the term also to lapses, errors and interferences with function. Not only have the latter the same unconscious roots as symptomatic acts but they may give useful indications of the type of unconscious defence exploited by the individual. In this sense they too are symptomatic.

Common examples of *false perception* are:—mistaken recognition (of strangers), failure to recognise (friends), misreading of letters or printed matter, confusion of places or scenes. Minor disturbances of *memory* are also of two main types, failure to remember and falsification of memories. Forgetting names, dates, appointments, promises, commitments, intentions or resolutions are of the first type. Falsification of memory also affects names, dates, promises, etc. *Slips of the tongue*, unintentional manufacture of neologisms, Spoonerisms, etc, are an everyday occurrence. *Slips of the pen* though less abundant commonly affect dates, addresses, names; but they can also disturb more complicated forms of written expression. *Erroneous actions* are extremely common. They are either positive or negative in type, i.e., an action may be carried out wrongly or it may be inhibited by a preparatory action, e.g., mislaying objects, keys, money, by which a later intended action is prejudiced.

In many instances the motive for these lapses can be recognised in the pre-conscious system, and as a rule it is possible for any objective observer to discover the immediate cause of his own slip actions etc., by using associative methods of thinking. He can thereby prove to his own satisfaction that disturbances of rational thought, speech and action, however absurd they may appear, can be *explained* by the interference of secondary systems of thought or action. These seize on the intended thought and action and distort it for their own purposes. To this extent lapses, errors and symptomatic acts resemble the compromise formations that are to be found in symptoms: wishes of an anti-thetical nature are both expressed in the final formation. This holds true even in cases where failure of perception alone occurs. When an individual fails to recognise his own grown-up son, or his own house, or his own shabby coat hanging on a restaurant coat-stand, we are entitled to assume that a deeper negative wish has held the more superficial positive wish in suspense. This is even more obvious in the case of false recognition. Mistakes in reading the superscription of an envelope leading to opening someone else's letter is capable of explanation at both pre-conscious and unconscious levels, particularly if the indi-

vidual happens to be in a state of jealousy. Similarly with forgetting and falsification of memory. When a prospective hostess, forgetting a dinner appointment, meets the invited guest in the street and greets him with unaccustomed effusiveness, it is not hard to guess that the friendship has worn thinner than either of the parties realises. The resemblance to the mechanisms of hysterical amnesia is extremely close.

In slips of the tongue and pen the resemblance to symptom formations is even closer and the compromise formation consequently easier to detect. In most cases the secondary element represents some immediate emotional factor of attraction or repulsion, but in either case the element is one that by itself would arouse some degree of conflict or inhibition. This is illustrated in the well-known slip of the medical student who, speaking of an intended visit to the Gaiety Theatre to see the chorus girls, informed his parents that he was going to see the 'coitus girls'. Sometimes a more permanent unconscious pattern is hinted at, as where confusions of the gender of pronouns indicates an unconscious homosexual interest; or where the individual substitutes his own name for that of the person to whom he is writing, a narcissistic identification usually based on envy or jealousy. When a father, writing to his son congratulating the latter on his approaching marriage, ends the letter with the phrase 'your affectionate son', an element of ambivalence and at the same time of identification is certainly operative.

The same can be said of erroneous actions. When the tired business man, returning to a nagging wife, tries to open the front door with the office key, the motive for his action scarcely needs interpretation. A typical example of erroneous action is observed in psycho-analytical work. When a patient coming to analysis takes a bus going in the opposite direction or rings the bell of the house next door, or, having greeted the analyst with the word 'good-bye', walks out of the room, we can safely infer that his relation to the analyst is, for the time being at any rate, a 'negative' one. The mislaying of objects is of special interest in that it is part of a *diphasic* reaction, thereby resembling the structure of an obsessional system. When a patient whose general physician has advised him to cut down drinking finds that he has misplaced the key of the tantalus, his later action (i.e. going for a drink) completes the diphasic situation, the first phase of which is represented by misplacing the key.

In normal individuals of a rather depressive type many errors in action indicate the existence of a masochistic and self-punishing tendency. This is easily observed in the so-called 'accident-prone' type, or in cases where the individual puts the lighted end of the cigarette in his mouth or having lighted a cigarette, puts the match in his mouth and throws away the cigarette. These reactions can also serve the ends of some current state of unconscious guilt.

A good example of a symptomatic act, (by which an unexpected and often incongruous action is interpolated in a sequence of adapted behaviour without, however, interfering with any other element in the series) can be observed when an individual, in course of entertaining a guest, has occasion to leave the room and in so doing switches off the light; or again, when a naturally disputatious person, giving vigorous verbal assent to a proposition, is observed to shake his head. A great number of symptomatic acts take the form of mannerisms and gestures. This involves a sub-division of the group into isolated and stereotyped acts. The depth of the disturbance can sometimes be judged by observing the frequency of the act. Isolated acts tend to occur during mental stresses of whatever nature or during states of mild intoxication. Deeper or more persistent conflicts usually give rise to more or less stereotyped symptomatic acts. But the motive in such instances cannot usually be detected by the untrained observer even with the help of associative methods of examination. Thus the unconscious homosexual frequently betrays himself, not only by his confusion of genders or by his habit of changing over to the outside of the pavement when walking with someone of the same sex but by his tendency to mix up 'right' and 'left'. In the last instance his reaction depends on an unconscious symbolism which cannot be broken down by free association.

It is necessary to add that although lapses, errors and symptomatic acts have many resemblances to symptoms and up to a point are capable of superficial analysis by any intelligent and objective observer, they should not be confused with clinical symptoms. The main distinction is one of adaptation value. In principle the clinical symptom represents an attempt to redress mental balance, which has been disturbed by instinctual crises. But in this case the price paid for a symptomatic redress of balance is maladaptation and suffering. In the case of the symptomatic act, the maladaptation is slight and transient; it can be rapidly corrected by conscious effort. Apart from an occasional feeling of embarrassment little suffering is experienced. Indeed many lapses, Spoonerisms for example, are a source of innocent amusement both to the perpetrator and to his listeners. Only when they occur so persistently as to cause inconvenience or vexation can they be valued as clinical 'signs' of disorder. The occasional lapse performs a ventilating function. It leads naturally to the assumption that the structure of the ego is rarely rigid, that it has a porosity as well as an elasticity which contribute to efficient function.

Needless to say, although the study of symptomatic acts is a useful preliminary to the study of symptoms, any aptitude in this direction the observer may discover in himself is subject to the accepted codes of professional discretion as well as of social decency. Social exploitation of analytical understanding does not differ from any other form of

rudeness or bad taste. In any case it usually ends in faulty diagnosis. To draw important conclusions on the strength of minor lapses and errors is as hare-brained as to diagnose septicaemia from the presence of a pustule on the chin.

## Chapter VIII

## SYMPTOM-FORMATION

Like all other psychic end-products symptom formations cannot be satisfactorily explained in terms of descriptive psychology. As in the case of dreams and symptomatic acts, they can be understood only if we apply to them in turn the usual methods of metapsychological approach, viz. dynamic, economic, structural and developmental (or serial). No one system of analogies is capable of expressing any mental relationship. Nevertheless before considering the process of symptom-formation in detail it is convenient to indicate the total function of any given symptom, a procedure, however, which involves the use of every variety of metapsychological terminology.

Psycho-analysis starts with the assumption that the mind is activated by certain instinctual forces, and that the main function of the mental apparatus is to produce an optimum balance of these forces, a state of affairs which depends on the capacity of the individual to *adapt* to the environmental stresses with which he is confronted. Now it can scarcely be denied that as the result of symptom-formation the individual's capacity to adapt is seriously impaired, and that in many cases his peace of mind is gravely disturbed. And as no satisfactory conscious explanation of these manifestations is forthcoming, we are entitled to infer that despite the apparent irrationality of its manifestations a symptom is an attempt initiated by the unconscious ego to adapt to some instinctual stress that is not recognised in consciousness. As we have seen, unconscious methods of dealing with stress are determined by the development of the mental apparatus during the formative period of childhood. Although differing in detail in every individual the main outline of development is the same in all cases. The unconscious ego has at its disposal certain mechanisms and in course of time develops a specialised institution (the super-ego) whose function it is to scrutinise the derivatives of instinct and, should they induce conflict, to lay an embargo on them. This fiat is then carried out by the unconscious ego using the appropriate mechanisms for dealing with charges of instinct. Normally these mechanisms either control or successfully redistribute the energy causing the tension. *A symptom is therefore a sign of active unconscious conflict, in which the unconscious control or redistribution of forces has not been successful.*

The next step in formulation depends on a closer examination of the symptom itself. *Many of the familiar clinical features of symptoms are due to the reactivation in an adult setting of infantile situations, mechan-*

*isms and affects*. And as a rule these can be recognised as belonging to one particular phase of development. The fears, rituals and inhibitions observed in adult disorders have existed in childhood. We may therefore conclude that *regression* plays an important part in symptom-formation. In other words, the main defence of the unconscious ego to a threatened stress consists in abandoning some adult relations to reality and carrying out a partial retreat to an appropriate period of infancy. The period chosen is the period during which the mind first experienced stresses of a kind similar to those by which the adult is now threatened. No doubt this regression is determined also by the wish to mobilise the same infantile mechanisms by means of which the child endeavoured to cope with its original conflicts. *There are in fact two varieties of regression to be considered in symptom-formation, a regression of instinct and a partial regression of the ego.*

In neither case can the result be regarded as satisfactory. Instinctual regression wakens up old conflict, and ego regression reinforces older mechanisms of defence. Nevertheless for the time being the mind appears to be fortified by these backward movements, and proceeds to advance on its reality problems, bringing with it however a now excessive charge of infantile instinct. It then sets up within the confines of the adult ego what might be called a 'provisional infantile government', which more often than not fails miserably to govern. It will be seen therefore that *a symptom is in part a spontaneous attempt at self-cure*: a fact which more than any other explains why many mental disorders are hard to cure. The unconscious mind in such cases prefers its own methods of treatment and the conscious mind has not the necessary forces at its disposal to withstand this temptation.

Like all other mental processes, symptom-formations can be described in temporal or spatial terms. Despite the variety of clinical manifestations the *symptomatic series* of movements, or, as the case may be, the *symptom structure*, is roughly the same in all cases. From the topographic point of view, the position of the symptom can be inferred from the mixture of unconscious and pre-conscious elements of which it is constituted. *The symptom is a psychic construction straddling the barrier between the ucs and the pcs and drawing energies from both systems.*

Having outlined the various angles of approach to symptom-formation, we must now consider the process in detail; and, as in the case of dreams and symptomatic acts, it is convenient to commence at superficial levels, looking all the while for dynamic factors. Now although the internal causes of stress leading to symptom-formation are unconscious, a few questions may elicit the fact that before the breakdown some real event of unusual significance has occurred; onset of puberty, engagement, or rupture of engagement, marriage, child-



bearing, climacteric, illness or deaths in the family, rupture of friendship or forced contact with uncongenial people, changes of residence or occupation, success or failure in work, loss of money, personal illness, etc. In the last analysis this *precipitating factor* involves a change in the distribution of instinct energies. Either there is some interruption of current gratifications causing both frustration and hurt (deaths in the family) or (as in the case of engagement to marry) there is an increase in instinct tension causing unconscious anxiety. In some cases the apparent precipitating factor (e.g. loss of or squandering of money, loss of occupation) is really spurious or has been unconsciously induced to provide occasion and excuse for a neurotic breakdown. Indeed many apparently obvious precipitating factors prove on closer examination to be 'covers' for other and more disturbing factors. A patient may complain of difficulties at work when in fact the real precipitating cause may be a setback in his love relationships or he may complain of a setback in love when in fact the precipitating factor is an outbreak of hostility in his social or occupational relations.

In other cases the breakdown may have developed gradually over a number of years in which case no very obvious recent precipitating factor may be found. In these instances it is usually possible to shew that a *summation of factors* has led to the ultimate breakdown. As a rule the frustrations that develop over a number of years are of one particular type. In such instances, therefore, it is scarcely legitimate to speak of precipitating factors, since the effect of earlier frustrations is *predisposing*. It is, however, a superficial predisposing factor to be distinguished from the *neurotic predisposition*, a constitutional factor that operates from infancy onwards. The clinical history of any case serves two main purposes, to establish the date of onset and order of development of the symptoms and to discover present and past sources of instinctual frustration which may have contributed to or actually precipitated the breakdown. As might be expected from the depth of the disorders, it is often difficult to establish an obvious precipitating factor in psychotic cases.

In all cases it is important to realise that whatever precipitating factors exist are in the nature of *frustrations*. For it is this disturbance of instinctual forces that sets a train of dynamic processes in motion. The first of these goes by the name of *introversion* of instinct. When the precipitating factor is an obvious one, it is sometimes easy to observe that a withdrawal of interest in external relations follows which is not only disproportionate to the immediate stimulus, but gives rise to a significant increase in phantasy activity. In other words the instinctual forces are beginning to free themselves from the controlling and binding conditions of reality relationship. A pathogenic charge of energy is in process of mobilisation which once set free is subject to the laws of

regression. It is important to note however that this *manifest regression*, with or without obvious cause, is only part of a greater *unconscious regression* occurring in all symptom-formations. If the forward flow of libido or other instinctual energy is interfered with the energy tends not only to withdraw but to flow back and activate earlier psychic interests. This can be observed in perfectly normal individuals, as when loss of or rejection by an adult love object is followed by an increase in need for child-like non-erotic affection or by an over-emphasis of childish character traits. But these normal regressions are only transient and are followed by efforts to establish contact with a new love-object.

In those about to develop symptoms the situation is different. Once started the backward flow does not stop until some *fixation point* is reached. In other words the course of the regression is not a matter of chance: it is strictly pre-determined. Fixation points lie deeply in the unconscious. They represent infantile phases during which libidinal and aggressive drives towards family objects were overcharged. The nature of the fixation depends on the vicissitudes undergone by these impulses. They may have been totally frustrated and so have given rise to powerfully charged systems of unconscious phantasy: or they may have succeeded in securing some measure of gratification and so have induced an intense longing to remain 'fixed' at that stage of development. In either case the unconscious exerts a 'pull' or 'attraction' on pre-conscious derivatives. This adds to the force of regression and also gives it its direction. During these early 'fixation' experiences the ego was compelled to acquire new methods of mastering tension of or overcoming traumatic experiences. And to the extent that these methods were successful, it acquired additional strength. Regression is, therefore, a retreat to these unconscious vantage points, satisfying also a need to re-establish old pleasures and old defences.

Strictly speaking regression is not in itself an abnormal process, as the phenomena of sleep and dream formation clearly indicate. Nevertheless it is convenient to speak of 'symptomatic' regressions implying thereby that the process ends in symptom-formation. Three factors combine to determine whether or not this latter process will ensue; first, a *constitutional* factor, namely, the predisposition to mental conflict which in turn depends on the individual's sensitiveness to anxiety and frustration, and the nature of his instinctual inheritance, e.g., lability of instinct, second, a *quantitative* factor, i.e. the amount of libido involved in the regression and, third, a *qualitative* factor, the variety of conflict originally developed at the fixation point. If during infancy conflict over unconscious impulses gave rise to neurotic or at any rate pathological forms of defence, these defences are reactivated by the regression. Hence the psycho-analytical formulation: *no adult neurosis without an infantile neurosis*. The process of re-activation

depends however on the quantitative factor. Early conflict may have been held in check by the power of repression. This power is greatly weakened when the immediate regressive charges of libido mobilised by the precipitating factor combine with the earlier repressed charges. *The accumulation of energies at the fixation point* puts too great a strain on repression which in any case tends to be faulty in those with a psycho-neurotic disposition. *It is well to remember, therefore, that repression is not itself the cause of symptom-formation.* Strictly speaking symptom-formation cannot be said to begin until repression has proved itself to be *at fault*, that is to say, has been unable to master the now excessive charges of libido.

Developments now proceed rapidly. Reinforced by the contributions of regressive libido, the *unconscious cathexes* now seek to break through the repression barrier and to a certain extent succeed in doing so. There is however no question of unmodified unconscious cathexes reaching the pre-conscious system. This is easy to understand when we recall, first, that the 'symptomatic' regression is not a total regression, a large part of the ego continuing to function normally and, second, that throughout life the unconscious ego is constantly on the alert to prevent repressed derivatives obtaining entry into consciousness. As we have seen defences against unconscious derivatives operate on both sides of the repression barrier (see repression). When repression fails the ego mobilises other unconscious mechanisms and a state of affairs arises which is very similar to that occurring in dream formation. The mechanisms of distortion, condensation and overdetermination, projection and displacement are called into play, as a result of which the unconscious wishes that pass through the repression barrier achieve only a *substitute and highly disguised form of gratification*. In view of this fact a symptom is rightly regarded as a *compromise-formation*. As well as gratifying unconscious wishes under strictly limited conditions, the symptom at the same time represents an unconscious *repudiation* of these wishes. This becomes more clear in cases where the symptoms cause a good deal of physical or mental pain, or when they handicap gravely the functions of the ego. These disturbances represent an unconsciously determined *self-punishment*, an admission of guilt on the part of the unconscious ego brought about by excessive disapproval on the part of the super-ego. But of course the mere fact that unconscious derivatives are disguised implies an attitude of rejection on the part of the unconscious ego.

As has been indicated earlier (see Psychic Systems) a certain amount of confusion arises from the necessity of using two approaches to unconscious phenomena, one in terms of the relation of the unconscious to the pre-conscious system and the other in terms of the psychic institutions, Id, Ego, and Super-ego. In the case of symptom-formation the earlier

systematic approach is essential to understanding the means whereby derivatives of unconscious cathexes obtain representation in the pre-conscious system. So far only the mechanisms of break-through have been described. But, as the clinical development of symptoms shews, once pre-conscious representation has been achieved, the way is open to exploit pre-conscious factors in the interests of the compromise. Particularly in the case of obsessional neurosis, logical relations characteristic of pre-conscious function are drawn into symptom-play and account for the extensive spread of compulsive thoughts and rituals.

Whereas the older systematic approach explains the detailed workings of symptom-formation, the approach in terms of Id, Super-ego and Ego institutions explains why both the repressed and the repressing (or other defending) forces are unconscious. The repressed forces are derived from the Id. They are detected by the super-ego which is for the most part unconscious and which, through the action of guilt, compels the ego to take defensive measures against the forbidden wish. But the part of the ego which takes these measures is also unconscious, hence *the effective processes of symptom-formation are from every point of view unconscious*. The part played by the pre-conscious in symptom-formation corresponds to the part played by secondary elaboration in dream-formation.

Although the main function of the symptom is to deal with unconscious conflict and although, precipitating factors apart, it may appear to have little or no connection with or bearing on current events, once it is well established *it usually enables the patient to exercise a direct influence on his immediate family, on his friends or on his social environment in general*. It is true that as a rule neurotic patients are at pains to conceal the existence of symptoms, sometimes indeed regarding them as shameful. Nevertheless it becomes obvious in course of time that they unwittingly extract a good deal of advantage from both family and friends, a state of affairs which repeats the experiences of childhood when illness usually brought in its train increased consideration or indulgence and a respite from the pressure of family regulations. The adult patient too secures at first a good deal of emotional consideration, attention and release from the responsibilities of adapting to existing or threatened crises. Not infrequently his treatment and upkeep are a constant drain on family resources. By the time the patience of his supporters is nearing exhaustion, the patient has established a kind of amoral ascendancy over them, a fact which suggests what is actually the case, viz. that neurotic and other symptoms can be exploited as means of unconscious revenge against persons (or their substitutes) who are unconsciously held to be responsible for their breakdown or who have been regarded as responsible, either wittingly or unwittingly, for inflicting injury or humiliation on the patient.

All this exploitation of environment is described as *secondary gain*. Strictly speaking it is a consequence rather than a cause of symptom-formation. Yet it is an important factor and has a direct bearing on the duration of illness which it tends to prolong. In forming a prognosis the factor of secondary gain should invariably be estimated. It has to be distinguished from *primary gain* which can be defined roughly as the relief from unconscious stress obtained by means of the defence mechanisms that are mobilised in default of successful repression. Both varieties of gain encourage the normal parts of the ego to 'come to terms' with the symptom. In spite of their sufferings which are often extreme, some patients develop an attitude to their symptoms that is difficult to distinguish from a form of affection. This becomes most obvious when in course of treatment they are threatened with the loss of both primary and secondary gain. In more technical terms the ego tends to *encapsulate* its symptoms, resists strongly any attempt to remove them and experiences a sense of loss when they begin to disappear. *It is clear that in such instances the synthesising function of the ego works to the individual's disadvantage.*

A word of caution about the nature of secondary gain. It must not be assumed either that this gain is a prime factor in symptom-formation or that the amount secured outweighs the discomforts of the symptom. It is necessary to emphasise this for two reasons: first, that there is a natural tendency to confuse secondary gain with conscious malingerling. Hysterical patients in particular are often roundly taxed with selfishness and laziness; in the second place the physician or indeed the patient himself, might be tempted to attack the neurosis by cutting off any obvious sources of gain. This procedure whether applied by the physician or by the patient is more likely than not to aggravate the condition. The physician should remember that secondary gain is a compensation for the primary loss that precipitates the neurosis. As for the restrictions applied by the patient himself, these naturally must be judged by their results; but as a rule the restriction is dictated more often by unconscious than by conscious ethical motivations, hence the manoeuvre usually defeats its own ends.

The outline of symptom-formation given above may be taken as valid for all psycho-neuroses. Variations in the clinical appearances of various neuroses are due in the main to (1) *constitutional* factors, (2) factors *determining* the form of the symptoms and (3) *precipitating* factors. Constitutional factors include (a) various types of *sensitiveness* to the effects produced by frustration and excessive excitation and (b) different degrees of *somatic predisposition*. These in turn are influenced by the *varying strength of the libido* at different stages of its modification,

by the *distribution of infantile sexual components* at different body zones and by the *degree of sadistic* (aggressive, reactive) *response* to frustration. Thus in the hysterias there is a hypersensitiveness to anxiety and the infantile genital libido is found to have been accentuated: in the obsessional states anal libido is reinforced and sadistic reactions to frustration play a prominent part in the neuroses.

The infantile developmental factors that predispose to neurotic breakdown and also determine the clinical form of the symptom turn on the *position of the fixation point* and on the *mechanisms characteristic of the period of development at which fixation occurs*. These factors in turn are influenced by the nature and severity of *environmental influences* e.g., emotional traumata experienced in childhood. In hysteria the fixation points usually lie in the infantile genital (Oedipus) phase, whereas in the obsessional neurosis the fixation is usually in the anal-sadistic (pre-genital) phase. In hysteria again the faulty repression leads to an accentuation of the mechanisms of projection, as in the phobia, whereas in obsessional neurosis displacement plays a more important role.

The influence of precipitating factors is both quantitative and qualitative. *Severity of frustration* tends to cause deeper regressions than the infantile development of the individual would otherwise lead one to expect. The *nature of the frustration* also influences the point to which regressive energies return. Thus in the hysterias the precipitating factors are usually concerned more or less directly with threats to genital love and genito-sexual gratification; or in adolescent cases with the threatened approach of adult experience. These factors tend to reactivate infantile fixations of an Oedipus type, although the amount of unconscious perverse phantasy present indicates that displacement to other levels of infantile sexuality has also occurred.

Another general distinction between the hysterias and the obsessional neurosis is the manner in which the symptomatic compromise is effected. Hysteria is generally described as a *monophasic* neurosis, implying thereby that the unconscious (disguised) gratification and the unconscious repudiation, together with the element of unconscious self-punishment, are represented in a single formation or phase. In the obsessional neurosis, where unconscious sadistic reactions play an important part thereby activating guilt as well as anxiety, it is not difficult to establish that the symptom is *diphasic*. One stage represents the unconscious gratification (crime) and is followed by another intended not only to cancel it or expiate it through self-punishment, but to make good the alleged damage to objects. This latter factor is described as unconscious *reparation* or *restitution*. In course of time these two phases begin to overlap whereupon the ego displaces the symptoms to a new psychic formation in which once more two phases can be detected; and so the process goes on interminably. In both hysteria and

obsessional neuroses the unconscious punishments and reparations 'fit the crime'. They are talion punishments and reparations.

*Comparison of the structure of psychoneurotic and psychotic symptoms* shews that although they have much in common, there are characteristic differences. When a precipitating factor is present the reaction of the psychotic patient is much more massive. Frequently no precipitating cause can be demonstrated; it appears that the psychotic reacts less to obvious relations with external objects than to the symbolic valuation of his general environment. Thus on a foggy evening a psychotic type may feel either comforted or contrariwise oppressed by deep sense of evil. The withdrawal of interest is also more profound, and affects relations not only to real objects but also to the mental images of objects. In other words investment (cathexis) of instinct is withdrawn from object imagos and returns to the ego. In the psycho-neuroses object imagos remain cathected. This psychotic withdrawal of object libido throws an excessive strain on the narcissism of the ego and predisposes to serious mal-function. In any case, psychotic individuals have seldom succeeded in establishing stable relations with real objects. Regression is more profound. The fixation points are much earlier, (within the first two to two-and-a-half years of life). Hence libido regression activates more primitive forms of infantile sexual impulse; similarly the ego reactions awakened belong to an early period when ego-synthesis is very weak and dissociation the rule. These factors lead to a more or less complete rupture with reality. In schizophrenia the rupture is more complete than in paranoia or manic-depression. Clinical features such as delusional and hallucinatory systems, are attempts to re-establish relations with the outside world by means of primitive mechanisms (e.g. projection). The attempts, it is true, fail, because they end by distorting true reality sense. Nevertheless like many neurotic manifestations these psychotic products are best understood when they are seen as attempts at spontaneous cure. The psychotic, as it were, plants his hallucinatory products at that point of his relation to the external world where he is actually suffering the greatest disturbance of instinct equilibrium.

Understanding of the similarities and differences existing between psycho-neurotic and psychotic formations is a useful preamble to the study of those processes which do not come into the category of 'symptom-formations' yet in the clinical sense are correctly regarded as 'symptoms' of mental disorder. Seen from the theoretical point of view the characteristic of a symptom-formation is that it represents an *enclave* established by the unconscious system in the territories of the pre-conscious. The ultimate function of the enclave is to support the weakened ego at the point where it has suffered its most serious loss or injury. A similar recuperative function has been noted in the case of the

psychoses. The point is of course that the remedy is worse than the disease. In the case of the psycho-neuroses the localization of pathological function in the form of a symptom-formation permits the rest of the ego to function without immediate interference. Yet the total result is, clinically regarded, unsatisfactory. Or to be more accurate, the physician is consulted by such patients as find their symptoms unduly painful or crippling. In the case of the psychoses although the technique of symptom-formation is the same, the ego-regression that accompanies the libido-regression is itself responsible for pathological disturbances of function which appear as 'symptoms' and which, in the case of schizophrenia and melancholia, affect the greater part of the ego. In paranoia alone can one observe a degree of localization of pathological function corresponding to that observed in the symptom-formations of the psycho-neuroses. All this can be made more comprehensible if we say that in the psychotic case the ego-regression to its fixation point, unlike the libido regression of the psycho-neurotic, does not remain unconscious. It obtains expression in thought, feeling and action.

There are however a number of 'symptoms' of mental disorder in which, although the *preliminary stages* of frustration, introversion, regression and reactivation of the repressed can be determined, the processes of *symptom-formation* differ from those we have already described. For purposes of illustration, the following types may be cited. The simplest case is that of *inhibition* of ego-function either *sexual*, e.g., cases of impotence, or *social*, e.g. reduction of sensory or intellectual function giving rise to forms of working incapacity, such as inhibition of visual acuity, of conceptual thinking and of various motor skills that are normally present. In such cases no enclave is established in the pre-conscious system; the ego solves its conflict by reducing to a low level these functions which might otherwise be exploited by the unconscious system for purposes of gratification. We cannot in such cases speak of a true symptom-formation. If however we regard the mental apparatus in its serial aspects as a *sequence* of activities following instinctual excitation and leading, under ordinary circumstances, to motor discharge, we can see that, without invoking the aid of symptom-formation, the ego is capable of inhibiting the process before it can secure motor discharge. The difference between this inhibition and what we call 'voluntary restraint' is simply that the inhibition is initiated by the unconscious ego, and that there is no phase of conscious reflection which usually precedes the operation of conscious restraint.

By way of contrast to inhibition certain *perversions* of social or sexual behaviour occur in which the ego attempts to solve its conflicts by securing discharge of tension through *exaggerated function*. In the case of sexual perversions it is easy to see that the regression characteristic of symptom-formations is also present but ends in the reactivation



of infantile components of sexuality. It is significant however that these regressive reactivations result, for all practical purposes, in inhibition of normal genital functions. Social perversions of behaviour are usually regarded as *eccentricities*. That they are also in the nature of regressions can be seen by studying the onset of miserliness in elderly persons. Some forms of regressive collecting mania are indeed characteristic of the psychoses; but the distinction is sometimes hard to make unless the object collected is completely devoid of ordinary reality value or indicates the reactivation of a primitive interest, as in the case of collecting pieces of soiled paper.

The term *eccentricity* provides a convenient bridge between the concept of perversion and that of *character abnormality* as indeed the term 'perverted character' already suggests. In abnormalities of character, however, the pathological process is more extensive. The individual exhibits peculiarities of conduct which sometimes affect every aspect of his character. In the classical instance no psychoneurotic symptoms can be detected by ordinary examination, although there is usually a history of both neurotic and perverted behaviour in childhood. Closer examination of these character peculiarities shews that many of them are capable of orderly classification in terms of the neurotic or psychotic conditions they most closely resemble. Thus it is legitimate to speak of *hysterical character*, *obsessional character*, *depressive* and *paranoid character* (querulance, litigiousness), implying thereby that the mechanisms to be found in the corresponding psychoneurosis or psychosis have influenced the social behaviour or affective discharges of the individual concerned. In this respect the conditions can be clearly differentiated from classical symptom-formations in which the disorder is localised or, to use ego terminology, in which the ego by sacrificing certain functions is able on the whole to preserve its integrity.

Some cases of character disorder have, because of their *social significance*, been given a special designation. The best example is that of *delinquency*. Here the last word in diagnosis has been claimed by the community and subdivision is effected in terms of penal and criminal codes of law. Psychologically speaking, however, a great number of these cases are simply affective and behaviour disorders. Here again the distinction between character disorder and classical symptom-formations is easy to effect. Not only is the ego affected in its social relations but a constant element of projection operates. Whereas the psychoneurotic attempts an endopsychic solution of his conflicts, a solution in which the environment is involved only in respect of secondary gain, the delinquent attempts to find a solution in his environmental relations. An essential part of his technique is an aggressive attack on person or property.

By combining the characteristics of the various groups in which

classical *symptom-formation* does not occur we can build up a symptom-picture which corresponds closely to that generally described as psychopathy. Here we find an assortment of symptoms. Some are in the nature of inhibitions of character, others quite definitely in the nature of perversions either sexual or social. Added to this, affective disorder is a striking feature giving rise to emotional crises in which feeling and conduct become impulsive and unstable. The character is frequently though not invariably eccentric or disordered.

The list given above by no means exhausts the varieties of mental disorder that do not conform to the laws of symptom-formation. Conditions such as *alcoholism*, *drug addiction* exist which are hard to place and which can only be understood after a close examination of their etiology. Thus drug addictions can be usefully classified into three main groups according to whether an unconscious homosexual factor, a depressive factor or a paranoid factor plays the predominant role. There are also types of drug addiction that supervene on a phase of psycho-neurosis. On the other hand the affective and social behaviour particularly of alcoholics sometimes corresponds to that observed in classical cases of psychopathy. The position of the group is in every sense *transitional*. It is desirable therefore to postpone closer investigation of these and other conditions until their clinical features are described. It is hoped however that the foregoing theoretical survey may be sufficient to enable the reader to find his way in the often confusing clinical account of mental disorders.



## SECTION II

### CLINICAL PSYCHO-ANALYSIS

Introductory.

Psycho-neuroses.

Psychoses.

Transitional Groups.

Psychosexual Disorders.

Social Difficulties.

Psycho-analysis of Children.

*Chapter IX*

## INTRODUCTORY

It is difficult to combine psycho-analytic practice with the exacting and irregular routine of general practice and in any case the practice of psycho-analysis calls for a lengthy and highly specialised form of training in the absence of which it is positively undesirable to attempt any form of analytic psycho-therapy. Psycho-analytical *understanding* is, however, of considerable value in arriving at the diagnosis and prognosis of mental disorder. It thus enables the practitioner to recommend the most suitable form of treatment. Moreover the prophylaxis of mental disorder depends on the recognition and appropriate handling of abnormalities in infancy and childhood, a task for which psycho-analytical orientation as to child development is essential. Needless to say if the physician has sufficient understanding of mental development to advise on the problems that beset children, he will have little difficulty in playing an advisory role with grown-ups. But there are many pitfalls to be avoided. The success of any advisory handling depends on the capacity to recognise the unconscious (infantile) patterns that influence adult conduct and to correlate these with the emotional setting that has precipitated conflict; and this in turn involves some understanding of the total function of the personality. Unless his advice is strictly regulated by these standards even an experienced psycho-therapist may fall into the error of confusing subjective prejudice with objective guidance.

More detailed indications for recommending psycho-analytic treatment will be given later. (See Section III). But it is well to be clear from the outset that, although the therapeutic range of psycho-analysis has gradually widened until it has come to include practically any form of mental abnormality, discretion must be exercised in recommending cases for psycho-analytic treatment. Even when the diagnosis is perfectly straightforward, e.g. an apparently simple phobia or obsession or inhibition, it does not follow that the patient will automatically respond favourably to psycho-analysis. He may accept a strong recommendation to undergo treatment and yet remain refractory, either because of his fears of mental 'interference' or because the primary and secondary gains derived from his illness, are sufficiently great to sap any effective drive to recovery. Even should he commence treatment, this type of patient may break off in a few weeks on one pretext or another. It is just as important, therefore, to recognise the existence of these 'pre-analytic resistances' as to distinguish accurately the clinical variety of

disorder. Naturally even a skilled observer is not able to estimate during a diagnostic interview the degree of primary gain, but a careful study of the patient's psychological setting should enable him to gauge with some accuracy the amount of secondary gain obtained. Actually the family physician has unique advantages in this respect and should be able to foresee difficulties that are not always obvious to the consulting psycho-analyst. If these should appear to threaten success the position should be explained to the patient but no pressure should be brought to bear on him. A brief delay will usually bring matters to a head. If a suitable decision cannot be arrived at in this way, recommendations of analytic treatment should be shelved. Many patients will turn to psycho-analysis only after they have tried every known form of non-analytical treatment.

In the last resort selection of cases for treatment depends on accuracy in differential diagnosis. For example, it is sometimes difficult to distinguish between hysterical and psychotic syndromes. Yet therapeutically regarded, there is no question that, owing to deep processes of dissociation and to the weakness of his relation to reality, the psychotic case is much more 'inaccessible' than the hysteric or, more strictly, has a more tenuous relation with the objects of his instincts and, therefore, will not respond to psycho-analysis to the same degree, if at all. A mistake in diagnosis leading to an over-sanguine recommendation of treatment will inevitably cause disappointment to all concerned. In severe sexual perversions, chronic marital difficulties, or persistent delinquency it is not easy to assess this *factor of accessibility*. Some abnormalities of character are more inaccessible than psychotic symptoms. In such instances pressure to undertake analysis should come from the patient's side and he should not be led to entertain sanguine hopes of an early cure. On the other hand, many severe cases are by no means so intractable as they look, and on occasion a threatened crisis can be averted by a rapid analytical exploration. Moreover, it is important to recognise that, particularly in the case of psychoses, symptoms may follow predetermined cycles, during some phases of which the patient is inaccessible to treatment. If a depressive case has already started on a downward curve or is entering on an agitated phase, it is more than probable that this phase will be completed, whatever therapeutic steps are taken. To recommend analysis at this stage is to court disappointment for some time ahead, and, as a rule, it is better to wait for remission in the cycle before commencing treatment.

Apart from personal training in psycho-analysis, the best method of acquiring the necessary judgement in these matters is to combine clinical experience with an adequate orientation as to the etiology of different varieties of disorder. In particular it is desirable to be able to estimate rapidly the significance not only of the classical neuroses and

psychoses, but of those numerous sexual, social and characterological disabilities that constitute a large part of psycho-analytic practice. The first step towards acquiring this capacity is to become familiar with the series of diagnostic and prognostic valuations that have been worked out for the neuroses and psychoses. Once the origin and development of these symptom-formations is understood it is easier to 'place' various aberrant forms or transitional types of disorder, or to assess those disturbances of character which, although more rigid than symptoms, for all practical purposes perform the same functions. Perhaps the most important diagnostic asset is a sense of the comparative *depth* of mental disorders. It is sometimes maintained that this capacity cannot be acquired without prolonged study in the psychiatric field. This may be true of the more obscure and larval forms of psychotic disorder, but it is certainly not true of the psycho-neuroses or of character disorders. No better field for the study of these conditions exists than the field of general medicine. The general physician who is trained in psychological diagnosis may often suffer from frustration of his efforts to help patients suffering from mental conflict but at least he has the satisfaction of knowing why so many cases of functional disorder remain refractory to organic methods of treatment.

## Chapter X

## PSYCHO-NEUROSES

For a number of reasons it is both convenient and desirable to commence a clinical survey of mental disorder by giving some account of the classical forms of psycho-neurosis. In the first place the psycho-neuroses are of common occurrence: in one form or other they are constantly encountered in general practice. In the second place, they frequently go undetected. This is particularly true of that variety of hysteria which manifests itself exclusively in the form of organic dysfunction. It is almost inevitable that many such 'conversion' hysterias should be treated in the first instance as disorders of organic origin and that a period of careful observation should be necessary before the mistaken diagnosis can be corrected.

Some part of this confusion is occasioned by the fact that medical psychologists themselves are not of one mind as to the subdivision of psychogenic disorders. In some cases this is due not so much to lack of clarity in clinical definition as to pre-conceived theories of neurogenesis. For some time clinical diagnosis was complicated by the existence of vague captions such as 'neurasthenia', 'psychasthenia', 'exhaustion neuroses', 'states' of anxiety and the like: and it is significant that the etiologies formulated to account for these conditions were frequently non-psychological in nature.

As investigation of the syndromes of conversion-hysteria, anxiety-hysteria and of obsessional neuroses proceeded some of this confusion was eliminated. The neurasthenic group, for example, was shorn of much of its significance. At the same time the category of psychosomatic disorder was greatly expanded. But this, although in many respects a desirable development, has introduced fresh confusion: many observers tend to lose sight of the *specific* etiology of the psycho-neuroses. This can be avoided only if the principles of psychic symptom-formation are kept clearly in mind. One of Freud's outstanding contributions to clinical psychology was the discovery of a *standard process or pattern of symptom-formation*. This was worked out in the first instance on the classical psycho-neuroses, and later applied to the psychoses. But not all disorders are comprised under these two headings and in fact the rationale of many functional diseases still remains obscure. On the principle, therefore, that it is easier to operate from the known to the unknown than *vice versa* it is desirable to isolate first of all those conditions which follow the classical pattern of symptom-formation, and to consider separately disorders which do not conform to



that pattern. An inhibition, for example, can be distinguished from a symptom-formation by the fact that it calls for activity on the part of the ego only. A sexual perversion may conceal unconscious conflict as effectively as and sometimes even more effectively than a psycho-neurosis: yet it cannot strictly speaking be called a symptom-formation. Some psycho-somatic disorders have an entirely different structure from that of a true psycho-neurosis.

Finally psycho-analysts give prominence to the psycho-neuroses for two special reasons. Psycho-analytical discoveries were originally made in this clinical field and the psycho-neuroses are still the conditions most suitable for psycho-analytic treatment. For this reason they are frequently called *transference-neuroses*, indicating thereby that they exhibit to a marked degree the tendency to form transference relationships on the analysis of which the success of psycho-analytic treatment ultimately depends (see Section III).

#### PSYCHO-NEUROSES

I. **HYSTERIA.** Two major types of hysteria exist, namely, *conversion hysteria* and *anxiety hysteria*. These can be distinguished clinically by the nature of their symptoms. In the first the pathogenic energies seek discharge primarily through *somatic* channels: in the second they are discharged primarily through *ideational* and *affective* channels. Patients belonging to the first group exhibit relative freedom from anxiety. Even when they suffer painful secondary affects, anxiety reactions are not prominent. The instinctual drives and counter-drives which would otherwise give rise to anxiety have been *converted* into physical symptoms. The unconscious phantasies associated with the conflict obtain (disguised) bodily representation, and the inhibiting and punitive aspects of the conflict are expressed through various bodily disturbances usually of a 'painful' character. By this method of unconscious displacement and compromise formation the development of anxiety is obviated.

Members of the second group on the other hand are martyrs to anxiety. This may be either *free-floating*, varying in intensity from vague foreboding and formless apprehension to seizures of acute irrational panic, or it may be *canalised by the formation of phobias*. In the latter case anxiety is aroused only in the specific situations which have come to be 'dreadful'. In both instances, despite the crippling and painful nature of the symptoms, the process is essentially one of spontaneous cure; in short an attempt to deal with situations of psychic tension which have aroused a sense of psychic danger and thereby compelled some form of spontaneous (mal)adaptation.

(a) *Conversion Hysteria.* At first sight the symptoms of conversion hysteria appear to involve any body organ or any physiological system.

This however is not strictly accurate. Although somatic in form, conversions symptoms are essentially *dramatisations of (unconscious) thought processes*. They constitute a kind of dumb-show. Hence they involve only such organs or systems as are suitable for unconscious purposes of dramatisation. This is the fundamental distinction between a conversion symptom and a 'psycho-somatic' symptom. A psychosomatic symptom may have been induced by psychic or somatic conditions or both; once formed it may be exploited in the interests of psycho-neurotic symptom-formation. But it has in itself no psychic content. *A conversion-symptom is throughout a somatic presentation having psychic content; it has a specific meaning*. With this reservation however it may be conceded that conversion symptoms affect a great number of organic systems and functions.

Classification of conversion states depends on whether systematic, descriptive, functional or etiological standards are applied. Thus *systematically*, they can be divided according to the organ or organic system mainly affected, or again into motor or sensory manifestations. *Descriptively* they can be classified by the factor of localisation or spread. They can for example be monosymptomatic or give rise to a variety of symptoms. Or again they may occasion either excess or diminution of the physiological *function* involved. They can also be *continuous* or *episodic*. If episodic they can be further distinguished by the degree of disturbance of consciousness manifested. They may, again, disappear by crisis or by lysis. Most clinical descriptions of conversion hysteria make rather indiscriminate use of all of these criteria, a method which is convenient rather than scientific. Possibly the best classification is in terms of *etiology*, in which case the various symptoms can be regarded as derivatives or end results of *specific repressed content* and classified accordingly. For convenience in presentation the systematic and etiological approaches will be mainly followed here. Some symptomatic criteria are however unavoidable.

*Motor* disturbances range from mild cramps, pareses, and tremors to disabling paralyses and fits or seizures. The distribution of such motor disturbances is functional rather than anatomical. Cramps and spasms and contractures develop without reference to organic systems of innervation. And the dysfunction is most frequently both variable and intermittent. Major convulsions ending in opisthotonos (*arc-de-cercle*) are now seldom met in practice. Some respiratory disturbances belong to this group: as, for instance, globus hystericus, aphonia, some forms of stammering and some asthmatical seizures. Intestinal cramps, colics, strangury and vaginismus are of this type.

*Sensory* disturbances are common. Anaesthesias, paraesthesias and hyperaesthesias of anomalous neurological distribution (e.g., the classical 'glove and stocking' type) may be of hysterical origin especially if

they are variable and intermittent. Frigidity is of the same nature. The *special senses* may be affected as when there is contraction of the field of vision, blindness or deafness. Hysterical 'hallucinations' are usually of a simple kind affecting smell, taste and touch. Hyperacusis is sometimes difficult to distinguish from auditory hysteria.

*Organ hysterias* affecting alimentary and circulatory systems are extremely common. The gastro-intestinal forms may resemble any type of organic dysfunction, e.g., anorexia, vomiting, flatulent dyspepsia, pseudo food-poisoning, diarrhoea, constipation, obstruction, 'liver' and intestinal colics, 'appendicitis' etc. Many anomalous skin and circulatory disturbances belong to the conversion group, e.g., pseudo-angina, various cutaneous eruptions and habitual blushing, also many types of uro-genital dysfunction, pseudo-cystitis, pseudo- (phantom) pregnancy, ovarian 'inflammations', vaginal 'discharges' and the like.

As has been suggested the main drawback to a systematic classification is that being concerned with end-results it does not throw any particular light on the *processes* of symptom-formation. This drawback can be corrected if we estimate conversion symptoms from a functional angle and if in particular, we keep in mind the *unconscious function* they are intended to perform. If, for example, we agree that there is an element of unconscious self-punishment in neurotic symptom-formations, it is only reasonable to assess conversion symptoms in terms of the physical *pain* to which they give rise. It will then become obvious that there are two main groups of conversion symptoms, on the one hand these formations in which a relatively painless inhibition of functions ensues, and on the other hand more active processes which give rise to experiences of, sometimes, acute somatic (physical) pain. The fact that many conversion hysterias are associated with physical pain throws more light on the economics of symptom-formation. Physical pain is less painful (or compelling) than mental pain and since most organic dysfunctions give rise to physical pain, one of the main 'advantages' of conversion hysteria is that the patient endures a physical pain instead of a mental 'punishing' pain. The best examples are to be found in the hysterical neuralgias and in the violent pains commonly called headaches. The peculiar feature of these hysterical pains is that the patient is able to endure prolonged and acute discomfort without any of the exhaustion phenomena that follow ordinary pain.

Yet another descriptive factor brings us closer to etiological assessments of conversion phenomena, viz., the manifest element of *dramatisation or organisation* present. As has been said conversions may be monosymptomatic or multilocular. But some of the more prolonged multilocular seizures have an obvious element of dramatisation and are often precipitated by some current emotional stress. A hysterical patient having been affronted by her husband may develop, first, a

selective hysterical blindness i.e., be unable to see him standing in front of her although able to see all other objects perfectly clearly, go on to develop a paresis of the right arm and hand (the attacking limb) and finally drop to the floor, responding to any attempt on the husband's part to assist her by going into a trance; in other words she exploits *already established* conversion symptoms to dramatise and give cathartic discharge to the reactions caused by the affront (secondary gain).

Finally a degree of *disturbance of consciousness* or of some conscious faculties; e.g., of memory and recall, is sometimes characteristic of conversion attacks. Many convulsive seizures are associated with loss of consciousness at the peak of the crisis. Fainting with all the usual accompaniments may exist as a symptom by itself or be associated with cardiac and circulatory hysterias. Dream states are regarded as belonging to the conversion group and sleepwalking in particular represents the acting out of hysterical phantasies in a state of dissociation.

*Etiological Factors.* Although conversion symptoms represent fundamentally the dramatisation of conflict over unconscious phantasies, their form and localisation are strongly influenced by the factor described as *somatic compliance*. The two best examples of this phenomenon are, first, the *localisation* of symptoms in accordance with distribution and fixation of body-libido (erotogenic zones) and the *fixation* of conversion symptoms on organs which have been over-libidinised as the result either of recurrent organic disease or of continuous hyperfunction. Thus, other things being equal, a case with constitutionally strong oral libido and an oral fixation will tend to have conversion symptoms of an oral type; and so with other components of infantile sexuality, anal, urethral, gastro-intestinal, muscular, cutaneous or respiratory. Similarly an organ that has been affected by frequent organic disorder may become the seat of a 'fixation' hysteria. In this case, however, the organ fixation is due to its hypercathexis with body and narcissistic libido. Fixation of a functional type is to be found in the various occupational conversions, writer's and pianist's cramp, tennis elbow and various pareses. Organs that normally act as discharge systems for anxiety, i.e., cardio-vascular, respiratory, gastro-intestinal and cutaneous systems are in any case predisposed to conversion.

The second pre-condition of conversion-formation is purely psychological, is in fact bound up with conceptual processes. All thinking is in essence a 'sample action' drawing the minute quantities of energy necessary for its 'activation' from the instinct causing immediate stress. Thought passes into action when sufficient instinctual force develops to give rise to motor and sensory innervations. In the case where no opposition, either internal or external, is offered to the action adum-

brated in the thought, the movement towards action is free and the action is appropriate to the impulse. Effective opposition to action naturally causes the thought cathexis to persist until some other form of instinctual control is mobilised to deal with the instinctual stress otherwise than by action. During this stage of persisting cathexis the thought can be described as a phantasy presentation. No active innervations occur. It is easy to surmise therefore that in conversion hysteria the instinctual stress has gone beyond the stage of phantasy-formation and has caused inappropriate innervations, i.e., *it is a kind of action which has gone astray*. Instead of producing behaviour appropriate to the gratification of the instinct (usually on external objects), the innervations have been directed towards internal (body) systems. These body systems are now supercharged with energy as the result of which their normal functions are disturbed. The conversion phenomenon therefore stands halfway between denial of action and purposive and adapted action. *It is essentially a compromise action*. The impulse is not fully denied yet its aim is distorted and its object changed.

But opposition to impulse is not due solely to external interference or voluntary internal inhibition. As has been pointed out in the theoretical section phantasy-formations derived from infantile instinctual frustrations remain active in the unconscious layers of the mind so long as the original instinct remains active. And it is part of the function of unconscious repression to see that these unconscious phantasies do not penetrate the pre-conscious system, or, at any rate that, if they do so, their form is effectively disguised. Repression that does not perform this function is technically *faulty*. Even in the case of the psychoneurotic however, faults in repression do not manifest themselves until the charge of the repressed impulse, and therefore of the repressed phantasy, has been augmented beyond a certain point. The condition which gives rise to this augmentation is known as *introversion*, the trigger-impulse of symptom-formation. Frustration of impulse in adult life tends to bring about a turning of libido from reality to phantasy. Phantasy is subject to the laws of regression. Hence the introverted charge of libido working in a regressive direction reactivates infantile (repressed) phantasy. Repression being faulty cannot deal with this additional charge. The repressed therefore breaks through but in disguised form. In phobia-formation a 'fearful' thought or situation develops: in conversion a 'fearless' action, but a distorted action, i.e., a physical symptom. The phenomenon of conversion can therefore be understood (a) as a result of faulty control of repressed phantasy, (b) as a diversion of action innervations into inappropriate and, teleologically regarded, disguised channels.

These explanations do not fully account for the phenomenon of conversion. It is clear however that the regressive processes following

introversion must activate increasingly *primitive thought forms*. These are much more closely associated with bodily innervations than are the more sophisticated processes of adult ideation. It is also clear from analysis of conversion hysterics that *the systems of infantile thought activated in the regression belong mainly to the infantile genital phase of development (Oedipus or incestuous phase)*. And as infantile genital thinking is freely expressed in symbolic form, e.g., a non-sexual part of the body can represent a genital part, it is inevitable that those parts of the body most adapted to *genital symbolisation* (arms, legs, head, throat and nose) should be readily affected by conversion symptoms.

The form of conversion symptoms is also determined to a considerable extent by the mechanism of *unconscious identification*. The organs affected (or in the case of such symptoms as vomiting and diarrhoea, the substances ejected) are identified with the sexual organs or substances of the person to whom the patient's incestuous wishes are unconsciously directed. This identification can be further complicated when the patient reproduces (unconsciously simulates) an actual illness from which the incestuous object may have suffered. Faulty repression, displacement and identification are in fact the main determining mechanisms of conversion-formation. Hence the subject is completely unaware of the nature of the pathogenic drives from which he suffers, and apart from pain and inconvenience, suffers no affective reactions.

Summing up these genetic aspects, we can say that the main factors in conversion-formation are (1) somatic compliance (2) frustration (3) introversion (4) regression (5) reactivation of an Oedipus situation which has been held in faulty repression and of which the negative (homosexual) aspects are strongly emphasised (6) breakdown of repression (7) displacement, symbolisation and/or identification with the incestuous object (8) breakthrough of innervations (9) inhibition or exaggeration of somatic function giving rise to crippling or painful symptoms (10) somatic dramatisation of unconscious phantasy formations including repetition of some elements that may have been actually associated with the Oedipus phase of development. In illustration of some of these factors the following case may be cited. A young wife, consciously devoted to her increasingly impotent husband develops a paresis of the hand. The frustration caused by his impotence activates the introversion, and at the same time sets up reactions of hostility to the love-object. Regression then reactivates an unresolved infantile conflict over incestuous attachment to her father to whom she had been strongly fixated. Her husband had in fact been unconsciously identified with her father. On the breakthrough of these repressed phantasies, the processes of displacement and symbolisation diverted energies to her own hand. The paresis then represented both the damage she wished to inflict on the husband's ineffective organ and the pro-

tective reaction against doing so, the loss of use of the hand at the same time punishing the patient herself. At the unconscious level the injured limb symbolised the penis of the frustrating father. The unconscious symbolism of hand-penis also enabled the patient to gratify her homosexual identification with the father, and at the same time the injury to the hand represented a punishment for her own infantile masturbatory impulses.

All of which is preamble to the general statement that *conversion-phenomena can be much more intelligently and intelligibly classified in terms of the infantile genital phantasy, i.e., the nexus of unconscious ideas associated with frustrated incestuous impulses. These flourish and ramify in the unconscious mind so long as the Oedipus situation remains under active (actual) repression, a state of affairs which is characteristic of all hysterical conditions.* To understand the different varieties of conversion we must therefore keep in mind the various components of incestuous phantasy, phantasies of intercourse with parents, unconscious theories of sexual activity occurring between the parents, fears of castration, theories of birth and baby making (which in turn are influenced by whichever form of component sexuality is preferred by the child), rivalry phantasies and destructive wishes activated by frustration and directed to parents and other children. Finally we must remember that infantile genital wishes are essentially *bisexual* in nature. A conversion symptom may represent any one of these elements but as a rule its meaning is overdetermined, combining disguised gratification of phantasy with inhibitions or excesses of function which are more often than not painful i.e., in the unconscious sense punitive. This is well illustrated in monophasic symptoms.

Armed with these formulations we can now review the various forms of conversion from the etiological standpoint. Fainting attacks and many convulsive seizures are frequently representative of orgasmic satisfaction of intercourse, usually phantasied as a violent seduction or rape, the associated phenomena of crying or screaming representing both the acceptance and the repudiation of the sexual attack. In most cases impregnation phantasies can also be uncovered. These are expressed in a great number of organic equivalents, feeding difficulties (oral impregnation), or gastro-intestinal disorders such as constipation (anal impregnation or bowel pregnancy). As has been noted they may actually give rise to phantom pregnancy. Globus hystericus represents displacement of intercourse and impregnation phantasies from below upwards. A fellatio element is common. Blushing and skin disorders may represent either inhibition or expression of unconscious phantasies and depend on an identification of the body with the genital organs. At the same time the exhibitionistic aspects of infantile sexuality are represented. Disorders of the motor systems are prominent in the cases

where sadistic (revenge) elements have played an important part in unconscious phantasy. They also represent and deny infantile masturbatory impulses. Sensory disorders usually represent compromises between acceptance and denial of the sensual aspects of infantile sexuality. Disorders of the sense organs have unconscious reference to early forms of sexual curiosity regarding parental sexuality, and frequently contain some elements of actual experience (the observation of primal scenes). Repetition of infantile circumstances associated with the Oedipus phase is observed in the phenomenon of enuresis, but is perhaps better illustrated in prolonged seizures, dream states, serial dramatisation of a number of hysterical identifications and in hysterical hallucinations. When repressed infantile phantasies are associated with actual organic illness or accidents occurring in childhood, a hysterical repetition of the original organic disorder forms the core of the conversion symptom. These repetitions prove on analysis to be cover-memories; as when an eczema of the forearm proved to be a repetition of an actual scalding experience which in turn 'covered' a repressed memory of circumcision behind which lay unconscious guilt over infantile masturbation and a core of Oedipus phantasy. The homosexual aspects of the Oedipus situation may on some occasions dominate the clinical picture, e.g. in anorexia and vomiting in men with unconscious fellatio phantasies, or in cases of mutism (tongue=phallus), finger anaesthesia, etc., amongst women. The gastro-intestinal disorders of unconsciously passive males are peculiarly adapted to represent and at the same time to reject unconscious homosexual phantasies of pregnancy. Attacks of migraine serve a similar purpose with women. Phantasies of possessing a phallus, with which the little girl hopes to impregnate her mother and thereby outvie her father are displaced from below upwards and at the same time expiated by the 'painful' headache and sickness that ensues. The 'splitting' character of the headache represents a castration phantasy but is overdetermined by an identification with the mother (head being split=abdomen being opened to remove the baby). Castration elements are represented in all cases of conversion hysteria, the more so if the repressed phantasies contain strong genito-sadistic elements activating revenge phantasies. By the operation of displacement and symbolism castration anxiety is expressed and at the same time denied through a painful disturbance of function in a non-sexual organ or body-system. In short, *study of conversion phenomena more than that of any other neurotic manifestation demonstrates the truth of Freud's doctrine that the Oedipus complex is the nuclear complex of the neurosis.* True, many of the symptoms represent also some elements of pre-genital sexual systems, but the genital element is nevertheless paramount. In this sense conversion hysteria is the purest form of hysteria.



*Diagnosis.* The major forms of conversion hysteria, e.g., prolonged dramatic seizures, dream states, convulsions, faints and somnambulisms are not difficult to recognise, although sometimes narcoleptic phases, rigidity and somnambulism may be hard to distinguish from the stupor and catatonia of schizophrenia (q.v.) The various disorders of motor and sensory function including disorders of the special senses can be distinguished from neurological disorders by simple examination. The distribution of the former is not determined by organic innervations, is functional rather than anatomical; also their incidence is both variable and intermittent.

Nevertheless it must be admitted that diagnosis of conversions affecting the main body system is, to begin with at any rate, more honoured in the breach than the observance. Frequently it is arrived at by a process of slow exclusion, particularly after the usual therapeutic measures have failed to take effect. Even this is an unreliable criterion since the administration of drugs or other therapeutic agents operates as a transference procedure of the suggestion group and may bring about amelioration of purely conversion symptoms. *Actually the most reliable means of differential diagnosis is an accurate psychological examination.* Unfortunately this precautionary measure is seldom adopted where the practitioner is confronted by what seems to him to be a straightforward case of organic disorder.

The routine of systematic psychological examination is described elsewhere (see Section III), but the following points may be singled out here. Following Freud's formulation that there is no adult neurosis without an infantile neurosis, the physician should investigate carefully any evidence of neurotic or functional disorder in childhood. This should be followed by a routine investigation of neurotic reactions in later life. The history of previous somatic symptoms should be carefully scrutinised and correlations made with events of emotional significance occurring about the same period. Here the elements of anomalous incidence and distribution and the association of the breakdown with emotional and instinctual crises, engagements, marriage, separation, divorce, deaths in the family or other traumatic events, point in the direction of conversion-formations. The psycho-sexual life may not shew as many disturbances as in the case of anxiety hysteria, but a history of impotence or frigidity is of some significance. Apart from manifest signs of disorder in psycho-sexual function there are many behaviouristic and characterological stigmata of conflict over *unconscious* homosexuality which are useful pointers to emotional imbalance. A certain insensitiveness to the discomforts caused by symptoms, an absence of exhaustion where excessive fatigue might be expected, unexpected ameliorations when domestic or social conditions undergo any sudden change and sudden exacerbations without any organic

justification, all favour the diagnosis of conversion hysteria as against organic disorder.

The greatest diagnostic difficulties arise under the following circumstances (1) when functional disturbances have existed over a number of years and have finally been drawn into a conversion symptom-formation (2) when earlier organic disease has pre-disposed to later conversion-formation. Strictly speaking this condition is one of 'fixation-hysteria' but the tendency of the average diagnostician is to regard the appearance of the conversion-formation as a recrudescence of the earlier organic disorder, (3) when recovery from organic disturbance is unduly delayed e.g., when nausea and vomiting persist indefinitely after an acute attack of genuine food-poisoning, or a sprained ankle continues to give pain for weeks after all swelling etc., has disappeared. In these cases some delay or uncertainty in diagnosis is inevitable. In general any somatic disturbance for which no immediate and adequate cause can be found, may be legitimately queried as a possible conversion symptom and calls for careful psychological examination.

(b) *Anxiety Hysteria*. It has been suggested that conversion-hysteria is the purest form of psycho-neurosis. And to the extent that the unconscious (instinctual) causes of the condition are more or less completely disguised and that pathogenic derivatives of unconscious impulse life, namely, disordered ideations and affects, are successfully withheld from consciousness, it can also be called the most successful or effective form of hysteria. This is in keeping with the view that many of the symptoms of mental disorder are *attempts* at spontaneous cure. But for his somatic symptoms the conversion-hysteric would, unless carefully scrutinised, pass as mentally sound.

Employing the same criteria it might be said that anxiety-hysteria appears to be a conspicuously unsuccessful neurosis. And this view would seem to be borne out by the fact that many more anxiety-hysterics seek psychological advice and/or treatment than do conversion hysterics. The cardinal symptom of anxiety-hysteria is anxiety, yet analysis of the symptom-formation shews that this anxiety is, to put it rather loosely, a defence against anxiety. Not, it would appear, a conspicuously successful defence.

This apparent paradox can be better understood if we contrast the mode of instinctual discharge in conversion and in anxiety hysteria respectively and if we estimate this discharge in terms of disturbance of bodily and mental function. From this point of view conversion hysteria is seen to safeguard mental integrity of function by a discharge of mental tension through somatic channels, whereas anxiety hysteria sacrifices some degree of mental integrity to meet the necessities of mental tension. To general inspection, however, anxiety hysteria seems a

more natural and logical form of mental disorder since it consists of disturbed ideations and affects: and ideations and affects are after all the direct psychic derivatives of instinct.

Understanding of the nature of anxiety-hysteria is further advanced by study of the general function of anxiety. As been has pointed out *primary anxiety* is a *state* arising when the mind is subjected to excessive or overwhelming (*traumatic*) charges of excitation, whether caused by instinctual stress or by environmental stimuli or by both. But in course of development various means of controlling, or at any rate of reducing excitation are developed and *it becomes possible for the immature mind to exploit its original experiences of anxiety in the interests of mental defence*. Anxiety then becomes a *danger-signal*; in other words, by re-experiencing a modicum of primary anxiety on the *threat* of excessive or overwhelming excitation, the mental apparatus is able to take steps to avoid being thrust once more into a *traumatic situation*. In course of further development more and more conditions are established for, as it were, reducing the effective dose of *signal anxiety*. When this point is reached any exaggeration of normal anxiety may be regarded as a sign of threatened excessive excitation even if there are no manifest signs of danger to be detected by the observer or indeed by the victim of anxiety. Following this train of thought it will be seen that the anxiety hysteric is not so stupid as he looks: he is merely adopting measures of flight to older systems, in other words, regressive measures, in order to protect his mental integrity.

Unfortunately this developmental link between primal anxiety and later forms of anxiety, whether real or morbid, complicates the study of psycho-neurotic states. It makes differential diagnosis more difficult than in the case of conversion hysteria. Clinical study of the manifestations of anxiety shew that there are two main forms to be considered viz., free anxiety and fixed anxiety. Free anxiety varies in accordance with the *anxiety-readiness* of the individual and with the *charge* experienced. Any degree from mild apprehension to acute panic may be experienced and the somatic expressions also vary widely from mild muscular tension (anxious eyebrows) to convulsive hyperactivity or stupor. Fixed anxiety on the other hand although acute enough in all conscience is, owing to the conditions of fixation, more readily mastered. It can however on occasion give rise to panic reactions. Anxiety again can be either normal or morbid. In the former case it is aroused by real danger either subjective or objective in origin, and can be tested by the degree of realistic adaptation to which it gives rise. Morbid anxiety on the other hand develops either without obvious cause or in response to unrealistic dangers. The dividing line between real and morbid anxiety is never a sharp one. And this circumstance together with the fact that both psychic and somatic expressions of anxiety can follow purely

functional disturbances render the differential diagnosis of anxiety conditions extremely difficult. Under the circumstances it is desirable to begin by describing the classical forms of 'fixed' psycho-neurotic anxiety.

*Clinical Aspects.* In the case of conversion hysteria it was pointed out that although descriptive standards of classification are convenient enough, the most satisfactory classification is based on unconscious etiological factors. This applies with much greater force in the case of the anxiety hysterics. Here the physician is not hampered by the necessity of employing organic terminologies. He can if he likes classify phobias broadly in accordance with the *age-period* at which they are observed. There is indeed some advantage in distinguished infantile phobias (i.e. formations appearing up to the age of five years) from those occurring in the post-infantile period. Thus the infantile phobias commonly observed are those of noise, of being alone or deserted, of the dark and of strange objects or persons. It is also possible to subdivide the post-infantile phobias into rough groups, e.g., latency phobias, pubertal and adolescent phobias, phobias of middle-age and the regressive phobias observed after fifty years of age. Quite clearly the infantile phobias are influenced partly by the phase of infantile *instinctual* development at which the child has arrived and partly by the degree of expansion of its interest in and *knowledge of the object-world* (external reality). Similarly the post-infantile phobias are affected by the stage of adult instinct development or by regression. But although the forms elected at different stages of adult life vary, their pattern is the same in all cases.

Phobias can also be roughly classified in terms of their *psychic localisation*, or more accurately in accordance with the *position of the phobia in an ego-object series*. Thus some phobias are concerned with the subject's own body e.g., illness, dirt on the skin, eating, defaecation, disfigurements or abnormalities of organs, organic diseases, going mad, exploding and the like. They might indeed be called narcissistic phobias. Others are concerned with objects in the external world which nevertheless are closely associated with the body and its functions, e.g., food, spoons, knives and forks, various articles of clothing, towels, dirt, excretions, lavatory pans or cisterns. In the third group an independent phobia object or external phobia situation or sensory stimulus coming from without exists. The object may be either animate, inanimate or phantastic, e.g., fear of dogs, of knives, of ghosts, of closed spaces, of thunder. In general therefore it may be said that the *spread* of phobia formations follows closely the *lines of displacement* of instinctual interest from body to food, excreta, clothes and so to independent external objects or situations.

All phobias are capable of sub-division according to the type of injury apprehended, e.g., poisoning, contamination, infection, suffocation, wounding, laceration, crushing, death. And each of these types can be further divided; phobias of physical injury, for example, can be sub-divided into phobias of being cut, stabbed, stunned, raped, of suffering amputation or fractures, of head or stomach injuries and the like. These *situations of physical danger* can be usefully contrasted with phobias concerning apprehended *mental danger*. Phobias of head injury for example have their psychic counterpart in phobias of going mad. A claustrophobia can be induced by wearing a tight finger ring, being in a closed or narrow space e.g., a small room or a room with locked doors or closed windows, an overheated room, a corridor, narrow street or crowd; but it can likewise be induced by the *idea* of being buried alive or by a psychic situation where the individual feels 'hemmed in' e.g., by social circumstances or difficulties, even by contact with a mentally aggressive or emotionally oppressive individual.

*Etiological Aspects.* Consideration of these various categories, in particular of serial and ego-object variations and of the fact that so many phobias are concerned with injury inflicted by persons or external objects suggests what is in fact the case, namely that the unconscious mechanisms of *displacement and projection* play an important part in localising the danger-situation. When in addition it is realised that the equally unconscious process of symbol-formation operates in precisely the same way as it does in dream-formation, many apparently irrational fears become more comprehensible. Many persons for an hour or two after waking are still affected by the anxiety they have experienced in a dream and react to real life with undue trepidation. Phobias are in fact measures taken to counter anxiety of endopsychic origin, in which a substituted or projected *condition of anxiety*, disguised and given symbolic expression, serves to conceal the true unconscious source of anxiety. A fear of genital injury (castration or mutilation) can be substituted by a fear of injury to the head. Here the danger is displaced from one part of the body to another, from a sexual to a non-sexual part. Displacement likewise accounts for the substitution of a fear of the *situation* which might cause injury for the fear of the injury itself, e.g., fear of being in high places from which one might fall and injure the head or fear of diving. When displacement is further complicated by projection so that an *external object* becomes the source of danger, a much wider scope is afforded the defences against castration anxiety. Thus the head may be thought to be in danger from falling objects (walking under ladders), from cricket balls or a hundred and one external sources. In all such cases the symbolism head = penis plays a decisive part in disguise.

At this point one of the functions of phobia formation becomes

evident. It lies in increasing the *psychic distance* between the unconscious source of fear and its expression in fear of a consciously recognised situation or object. Another advantage of the phobia formation is that *as a rule the patient can remain free from anxiety so long as he avoids the conditions that are alleged to precipitate it.* To a city-dweller, for instance, a phobia of snakes is much more advantageous than a dread of being poisoned by exhaust gases or of being run over by a bus.

The apparent paradox that a neurosis intended to defend against anxiety gives rise to acute and unjustified anxiety can best be understood by recapitulating Freud's theory of anxiety. Primary anxiety is essentially a traumatic state during which the individual experiences overwhelming quantities of excitation which it is unable to master, as e.g., during the process of labour and birth. The anxiety experienced in later states of danger is a sample re-experience of primary anxiety. This sample operates as a danger-signal. Anxiety arising from a threat of danger enables the individual to take steps to avoid the danger. During the infantile stages of development, however, the child reacts as much to dangers that are (from the observer's point of view) unreal as to real dangers. It will for example shew as much anxiety about the temporary disappearance of its mother as about her permanent disappearance or death. It is this capacity to react to (what the observer knows to be) unreal danger that is exploited in phobia formation. An unreal danger from without is preferred to an actual threat from within.

But what are these greater dangers? For obviously there is no real danger in most phobia situations. The answer is that the dangers are of unconscious origin; first, the danger arising from *increasing unconscious excitation* that occurs when repressed impulse reinforced by charges of introverted libido threatens to break into consciousness; and, second, the danger that originally initiated the repression of the unconscious impulse, i.e., *fear of punishment* for a tabooed impulse. *As in the case of conversion hysteria the unconscious impulses belong to the genital incestuous phase of childhood (the Oedipus situation), and the punishment dread is genital castration or mutilation.* Hence the constant element of genital symbolism in all hysterical phobias. The stages of *symptom formation* are identical in both forms of hysteria; only the technique of defence is different. When, owing to faulty repression, the adult ego is threatened with the break through of repressed Oedipus wishes, it reacts as it did during infantile crises. It tries and in a formal sense succeeds in projecting and displacing the conditions of anxiety. In other words an adult phobia is invariably built on the residue of a phobia present in childhood, though not necessarily in the same form; it involves the attribution to the object or situation feared of reactions of aggression, a punishment for the unconscious incestuous wishes reactivated by regression following frustration. Herein lies the neurotic bargain of

anxiety hysteria. The patient endures constant or recurring attacks of unreal (morbid) anxiety in order to make good the fault in repression and remain in ignorance of his unconscious wishes. At the same time some of the repressed excitations are actually discharged in the formation, thereby illustrating the element of *compromise* characteristic of all neuroses.

We are now in a position to review the commonest forms of phobia in terms of their etiological significance. To take by way of illustration a common monosymptomatic phobia, the *fear of knives*. A patient suffering in this way turned out to have strong 'Jack-the-Ripper' phantasies, behind which lay repressed wishes for incestuous intercourse. By displacement and symbolism the genital elements were displaced (knife=penis: abdomen=vagina) and at the same time an infantile sexual theory of delivery of babies through the abdominal wall was represented. The attitude to the mother was highly ambivalent but the idea of sadistic intercourse was projected as well as displaced. Moreover a strong passive feminine disposition was responsible for the idea of being attacked by a knife (penis), which represented at the same time a talion punishment for the positive incest wish (castration by cutting). Knives not only aroused fear but antagonism. When opportunity arose he would damage, destroy or throw them away. The feeling of shame associated with the symptom, which he did his best to conceal, was a response to the element of gratification of libidinal excitation.

Not all phobias are so rigidly determined as this. Either there exists a cluster of associated phobias or one or two phobia formations are strongly over-determined. *Fears of being alone* although present from early infancy acquire a special significance in the Oedipus situation; they indicate in particular a fear of masturbating or of sexual excitement. This becomes clearer in the case of *fears of open spaces* e.g. streets which represent fears of active or passive sexual experience or adventure. At the same time *agoraphobia* is stimulated by exhibitionistic or viewing tendencies. *Traffic fears*, fears of travelling in carriages, motors, buses, trains, tubes, trains, ships, aeroplanes, etc., are usually over-determined. Symbolically they represent the 'dangerous' act of incestuous intercourse but are complicated by unconscious masturbation anxiety; in short they are aroused by any condition of libidinal excitation. They also include an element of *fear of closed spaces*. The typical *claustrophobia* is usually associated with phantasies of being in the mother's womb but this 'regressive' sexual theory covers a fear of incestuous coitus both active and passive. Fears of being *buried alive* or *suffocated* are of the same nature. Fears of *being run-over* represent in the case of males a passive feminine disposition, in the case of women positive incestuous phantasies. *Fears of high places* imply not only a fear of sexual excitement but more specifically of erection and orgasm. In the

case of women a positive Oedipus element is present (fall=Oedipus-seduction). In *stage fright* and *fear of examinations* a strong exhibitionistic factor is present in combination with masturbation anxiety. Although *fear of the dark* is one of the primary phobias of infancy, by the time it is drawn into a true phobia formation it has acquired a much more complex content. It is still closely associated with fear of death or separation but its most characteristic determinant is fear of the 'primal scene' (observed or phantasied coitus between the parents). In course of development fear of the dark becomes narrowed down to fear of cupboards, attics, undergrounds or dark woods and the like. The *fear of strangers*, originally a threat of separation from familial objects, is also exploited in the defence against incestuous phantasy. By displacement it becomes attached to burglars, tramps, soldiers, policemen and other simple forms of father-substitute. *Fear of ghosts* is of the same nature. The significance of *fear of animals* depends on the particular facet of the Oedipus situation represented. Generally speaking animals represent parental objects, some obviously male, others female. In most instances the fear of the attacking animal is derived from castration anxiety. As a rule small animals and insects represent either genitals (mouse, caterpillar) rival children (fleas, wood-lice), semen (body-lice or faeces, small black beetles). Some animal phobias are bisexual in content, as in the case of spiders which represent either father or mother or alternatively male or female genitalia.

In the case of phobias concerned with the state of the individual's own body, the genital factor still prevails but is reinforced by repressed phantasies derived from other erotogenic zones. *Food phobias* are due to impregnation phantasies displaced to the oral zone and reinforced by anxiety over oral sadism. These two elements can be simultaneously expressed, for example, in repressed fellatio phantasies. *Fears of illness, of deformity, insanity, heart disease, tuberculosis, venereal disease* are usually displacements of castration anxiety. *Erythrophobia* has an exhibitionistic or scopophilic element. *Fear of cancer* combines fear of castration with fear of pregnancy. *Fear of thunder and lightning* derive from phantasies of the primal scene, the former having an additional anal-sadistic element and the latter an exaggerated castration significance. *Fear of drowning, of anaesthetics, of fainting, and of death* combine a number of elements. They represent coitus fears, fear of punishment for death-wishes due to rivalry, and fear of sexual excitation and/or orgasm.

*Diagnostic Aspects.* Although the factor of displacement from genital to other areas of the body and the factor of projection from the body (genital) to external genital objects, account for the final localisation of anxiety, it is clear that *pre-genital* elements also contribute to phobia formation. This is regarded as being due in the main to a *defensive regression*



from genital to pre-genital levels, and is seen typically in food phobias (oral regression), in animal phobias in which the dreaded situation is one of being bitten (oral regression from castration phantasies) and in many of the dirt, contamination and disease phobias (anal-sadistic regression). Deeper analysis shews however that pre-genital conflicts can give rise independently to what might be called 'pre-genital phobias'. This is borne out by the fact that some apparently hysterical phobias, particularly of dirt, contamination and smell, may in course of time develop into obsessional ideas, accompanied however by some amount of conviction that the dreaded situation is a real one. If this conviction should increase the condition is indistinguishable from a hallucination or delusion. For this reason fixed and intractable monosymptomatic hysterias are to be regarded with some suspicion. An isolated fear of baldness, for example, though apparently simple in content and having obvious symbolic references to castration fear may prove to be a cover for (defence against) an underlying paranoid construction.

These facts have an important clinical and theoretical bearing. They suggest the desirability of distinguishing between 'paranoid phobias', 'obsessional phobias' and true 'hysterical phobias'. These distinctions are however not easy to make in practice. Differential diagnosis depends on determining the depth of regression and on establishing whether or not severe conflict existed during the infantile years. Sometimes the stigmata of unconscious homosexual difficulties (q.v.) are of diagnostic value. As with conversion hysteria, a bisexual factor can always be detected in anxiety hysteria. In most female hysterics the infantile incestuous phantasies have a strongly masculine (phallic) character. Similarly the male hysteric frequently identifies himself with his mother and sets up defenses against passive feminine and impregnation phantasies. The more highly charged and more primitive the aggressive (sadistic) components present the more likely it is that the hysterical phobia covers obsessional or psychotic reactions. A marked food phobia has obvious resemblances to a delusion of persecution by poisoning.

A distinction between anxiety phobias and 'paranoid phobias' is all the more necessary in the case of children whose anxieties are more clearly 'paranoid' in type during the first three years and shew true hysterical form only in the third, fourth and fifth years. Even normal children exhibit early anxieties of a persecutory type. Some observers have been misled by these observations into postulating a paranoid basis for all infantile phobias. This error is due to neglect of etiological considerations. *The true anxiety hysteria is an infantile genito-sexual phobia.* Since however some clinical resemblance exists between genital phobias and pre-genital anxieties, differential diagnosis depends less on the clinical form of the phobia than on the absence of other symptoms

or reactions indicating graver disorder (see following chapters). It is sometimes possible to make a distinction between hysterical and other phobias by studying the symbolic significance of the phobia-object or phobia-situation. Where the representations are purely genital in type, fear of knives, mice, burglars, small apertures, penetrating wounds, etc., or where they suggest the existence of genital pregnancy phantasies, e.g., phobias of insects, eggs, etc., the probability is that the case is one of pure hysteria. Much more work remains to be done along these lines of differentiation.

General diagnostic measures of a kind similar to those adopted in the case of conversion hysteria can also be employed. Anxiety hysteria is more common in women. Apart from difficulties due to the symptoms themselves, the patients usually give an impression of satisfactory adaption to reality. There may be a good deal of emotional instability, with a tendency to pass into emotional crises whenever psycho-sexual or aggressive tensions arise. And their capacity for partial dissociation is well exhibited in their capriciousness of memory and that isolation of symptoms from the ego which was formerly described as *la belle indifference*. Apart from this capacity for dissociation the personality seems, contrary to the popular impression, well integrated. In some instances hysterics conceal behind an apparently child-like character a well poised and superior personality. But they regress readily into childish states.

In the majority of cases particularly when a cluster of phobias is maintained, anxiety hysterics extract a considerable unconscious advantage from their symptoms. They usually dominate the household of which they are a member and can marshal their various phobias to meet every awkward emotional contingency. So marked is the factor of *secondary gain* that it has been regarded by some observers as an etiological factor. But this is to confuse hysteria with simulation and *ma-linger-ing*. The continual exploitation of secondary gain is, however, a good diagnostic pointer. In doubtful cases the quality of love-interest and the nature of object relations may help to confirm the diagnosis. Hysterics display an over-readiness and over-intensity in their attachments, but the range of their interest at any period is usually limited and combines over-solicitousness and anxiety with a tendency to sudden rages. Their psycho-sexual life is frequently interrupted by phases of mild frigidity or impotence.

II. OBSESSIONAL (COMPULSION) NEUROSES. Although comparatively easy to recognise, the obsessional states are in every respect the most complicated of all the psycho-neuroses. The clinical symptoms are usually elaborate, and capable of detailed sub-division, the unconscious

mechanisms in operation involve almost every branch of mental activity, the etiology is complex, prognosis is uncertain and treatment difficult.

*Clinical Aspects.* The name given to this group of neuroses indicates the leading feature of the symptoms. When, for example, a man of blameless antecedents constantly imagines himself stabbing his wife with a breadknife and is not only unable to free himself from the thought but suffers pangs of guilt on account of it, it is no exaggeration to say that he is *obsessed* in his intellectual field of activity. We may therefore describe this constant preoccupation with a stereotyped thought as an *obsessional thought*. Similarly when a person finds himself compelled to wash his hands literally for hours on end, producing on occasion a soap eczema thereby, or when a housewife is compelled to wash all her carpets every day with carbolic soap, we can characterise this compulsive repetition of a stereotyped form of behaviour as an *obsessive or compulsive action*. When a patient complains that he spends hours of valuable time making up his mind whether to wear black or brown socks, thereby risking discharge from his employment for unpunctuality, the condition is well described as *obsessional doubt*. When we find his mind occupied by metaphysical speculations about the 'rightness' of some apparently trivial detail of everyday life, e.g., the significance of a certain arrangement of mantelpiece ornaments, we are entitled to speak of *obsessional rumination*. And when his dressing habits involve an elaborate series of dusting observances, dusting the wardrobe, the coat hanger, shaking each article of clothing, putting it on, taking it off, putting it on again, and once fully dressed, proceeding to brush the floor and every part of the bedroom with which his clothes have come or might have come in contact, turning the door handle with a duster in his hand and finally jumping out of the bedroom door before the real or imaginary dust can settle on him we are justified in describing this series of events as an *obsessional ritual*.

Obsessional formations are the easier to recognise in that most people have at one time or another recognised similar if less violent compulsions in themselves; e.g., muttering 'damn your eyes' under their breath whilst engaged in affable conversation, stepping over cracks, counting numbers, piercing fallen leaves with the ferrule of their umbrella, listening with superstitious interest to the striking of clocks becoming absorbed in aimless rumination, being unable to make up their mind where to go for holidays or pursuing a strict, inelastic and not very efficient ritual at the office desk.

Contrasting these minor obsessional habits or reactions with the neurotic variety we are able to make a distinction of some significance for whereas the ordinary person can 'carry' or 'harbour' minor obsessional forms without disturbance to his ego, the ego of the obsess-

ional neurotic is, to say the least of it, heavily handicapped by his symptoms. In some cases it is so interpenetrated by obsessions or burdened by a load of rituals, that it is not only unable to perform its legitimate functions adequately but is as crushed and colourless as grass growing under a stone slab. This *involvement of the ego* enables a useful contrast to be drawn between the obsessional states and the hysterias. In conversion hysteria the mere existence of a neurotic symptom often goes undetected by the ego, in anxiety hysteria the neurotic symptoms are unmistakable but are dissociated from the rest of the ego which may retain effective function ; in the obsessional neurosis the ego is directly involved. It behaves like a superstitious and guilty child, giving often a degree of rationalised assent to the 'necessity' for its behaviour. Even when the unaffected parts of the intellect admit the irrationality of obsessions, this repudiation is ignored by the total ego which slavishly obeys the compulsions. Nevertheless obsessional neuroses have obvious affinities with the hysterias. The *action* in conversion hysteria though more disguised and therefore unrecognised by the ego is almost as ill-adapted and absurd; the fear *thought* of the phobic is very obviously the obverse of the compulsive thought of the obsessional. Fear of dirt and contamination is, for example, cancelled out by a washing compulsion; fear of touching railings by a compulsion to paint railings. Some parachutists have described the compulsive nature of their interest in 'jumping' which is clearly a counter to the fear of falling from heights.

To these correlations we shall have occasion to return. In the meantime the extent of interference with ego-function can be estimated by means of a rough classification of obsessions in terms of their mental form. As has been pointed out in the theoretical section mental events can be ordered in a dynamic series from excitation to discharge. Instinctual tension gives rise to affect and ideation; ideation is followed by speech or action. Now obsessional symptoms are capable of subdivision in the same way. Given unconscious instinctual tension, precipitated or augmented by current instinctual stimulation or frustration, *obsessions may appear at any point in the tension and discharge series, affecting emotions, thought, speech or action.*

*Affective obsessions* without any obvious ideational content or attendant ritual are seldom observed. Even in the case of *folie de doute*, the doubt is commonly associated with a given thought or action or series of thoughts or actions. There is, however, an emotional type of this disorder in which the victim suffers from no stereotypy in thought and behaviour but from constantly recurring and swift *alternations of feeling*. There is no indication of the source of the feeling; the patient for example knows only that whenever he experiences a state of internal 'goodness' he *must* immediately experience a 'bad' state otherwise

disaster will follow. No doubt some of these are obsessive states the ideational part of which has been repressed and which correspond to the 'phobias of fear' experienced by anxiety hysterics. But their resemblance to manic-depressive alternations is not without significance. In the latter case, however, no element of 'mustness' is interpolated between the moods. Some men experience fleeting attractions towards women which again *must* be followed by feelings of repulsion; but here the object of the feeling is indicated. In the author's view these alternations of mood are derived from the pre-obsessional phase of infantile development. Sometimes conditions of *apathy* prove on analysis to be due to simultaneous experience of two opposing sets of feelings which cancel each other out. Alternation may be accompanied by anxious indecision and apathy goes with gross inhibition of action and experience of excessive fatigue.

Two main varieties of *obsessive thought* can be observed, one in which the function of thinking as a whole is involved and one in which isolated thoughts acquire a compulsive force. This second group can be further subdivided in accordance with the irrational content of the thought. Some are purely nonsensical ideas, others have originally had rational significance but have lost it in the obsessional process and others again are fixed ideas which have not lost their meaning but are either impossible of attainment, or unlikely to be put into action. In illustration of general obsessional thinking, the case may be cited of persons who are unable to pursue any logical process of thought whatsoever. Every stage in positive thought-formation must be followed by negative forms of thinking, either calling in question the previous formulation or flatly contradicting it. The resultant doubt is reflected in indecisive action. Nonsense thought formations are represented by compulsive concern with meaningless phrases or neologisms which are accompanied by painful states of embarrassment. Trivial ideas picked up on random reading become obsessive when they have lost any reference to their original context and are dwelt on to the exclusion of ordinary thinking. Many compulsive thoughts are concerned with phantasies of committing murder, incest or homosexual intercourse. More disguised varieties are concentrated on trivial acts of commission or omission, e.g., 'Have I or have I not turned on a tap or left a tap running'. These thoughts are usually accompanied by painful forms of doubt. In general, obsessive thoughts vary in accordance with the particular form of thinking preferred by the individual. Many are really visual images; others are of the most abstruse nature, e.g., speculations about virtue and value, the nature of sin, of religious belief, of justice and the like.

*Obsessive words* usually carry a stage further the process of obsessional thinking. The patient may repeat endlessly nonsense words and jingles or snatches of a 'secret' language, which cannot be understood

even by their author. In such cases the painful affect is represented by the scene of 'wearing' compulsion. In other instances some hint of the underlying problem is afforded by the compulsive use of obscene words, blasphemies and violent expressions. This is followed by a painful doubt whether or not the words have been overheard by some bystander. A man may for example be overwhelmed with doubt whether a woman may have heard him utter an obscene threat, a doubt which usually develops into the further uncertainty whether he actually said it or not. The obsessional neurotic unconsciously believes in the magical power (omnipotence) of words as indeed of actions. For him words, like looks, can kill. Hence compulsive words are frequently accompanied by compulsive gestures intended to cancel the effect of the words. The most disguised form of obsessional word-play takes the form of obsessive talking. To put it simply the patient cannot stop talking, a habit which is so common in the everyday life of so-called normal people that its pathological nature is frequently overlooked unless it happens to take an absurd, grandiose or maniacal form.

A lengthy catalogue would be required to enumerate even the principle forms of *obsessional action*. They can be divided into meaningless or nonsensical actions, the repetition of actions that have lost their original purpose, and the carrying out of actions that are intended to offset some obsessional thought or phantasy. Obsessional cases can be observed making minute gestures some of which are almost like tics, (q.v.), pinching the fingers together. Others are more obviously ceremonial; touching various parts of the body or various external objects railings, doorhandles, ringing bells, carrying out innumerable forms of cleaning and washing, and the like. Obsessive writing is partly a ritual action and partly an extension of obsessional word-play. Compulsive writing of obscene words or drawing of obscene pictures represent more positive forms. Compulsive writing of 'diaries' usually consisting of repetitions of trivial events represents a more generalised form of obsessional writing. Keeping 'lie-books' in which the peccadillos of the day are painstakingly recorded is a compulsive form of written confession which may in certain cases develop into compulsive confession sometimes of 'bad deeds' murders, etc., that have not in fact been committed by the individual.

Although it is convenient to distinguish isolated compulsive actions from *obsessional rituals*, no difference in principle is involved. Many apparently isolated forms of compulsive action are found to be residues of former rituals, and in fact most obsessions tend to grow to ceremonial dimensions, as, for example, in the case of a woman who took some four hours to get to bed, because every detail of undressing and arrangement of clothing, bed and furniture had to be exact; any slip in the ritual meant going back to the beginning and repeating the

whole process. Infection rituals can become extremely elaborate and in course of time interfere with almost every activity of every day life. Closer examination of the more lengthy rituals enables a distinction to be drawn between those that represent increasing *complication* of the original obsessive act and those that consist of a long drawn out series of *alternating actions*, in which the original obsessive idea is stated and then denied or undone.

It should be remembered, however, that the main clinical advantage of distinguishing between obsessive thoughts, words, actions and rituals lies in the fact that by so doing the observer is able to estimate the amount of faulty repression present. An obsessive action indicates a more serious fault than an obsessive thought. Moreover an obsessive action implies the previous existence or co-existence of obsessive thoughts. This is clear in the case of counting compulsions. The patient may be obsessed by mental counting; or he may count aloud; or again he may go through actions of counting, touching each railing, for example, with his forefinger; or he may experience simultaneously all three forms.

The system of alternating actions referred to above draws attention to the essentially *diphasic* nature of the obsessional neurosis. The compulsive system is divided into two parts, one part representing the doing of a guilty deed, the other, its undoing; e.g., a man who had a compulsion to untie and re-knot his tie dozens of times a day; the undoing represented, at the current level, freeing himself from his wife, the re-knotting, continuing to live with her. The element of unconscious *compromise* which in the case of hysteria is condensed in a monophasic symptom is extended in obsessional systems in such a way that part of the repressed and of the repressing elements become obvious.

The *manifest psychic content* of obsessions whether directly stated in obsessive thought or dramatised in obsessive actions repays close scrutiny. It is usually concerned either with aggressive impulses or sexual impulses or a combination of the two groups. The defensive parts of the obsession usually indicate whether the underlying fear and guilt is narcissistic in origin or whether it is concerned with instinctual objects. A contamination obsession, a washing compulsion, for example, may be intended to guard the self from anxiety or it may be intended to protect an object from injury. An individual who has jostled someone in a crowded street may be compelled to return repeatedly to the 'scene of the crime' in order to seek for evidence either that he has or has not caused harm. Many sexual obsessions contain elements obviously derived from *infantile sexuality*, frequently homosexual derivatives. These derivatives are, however, devoid of erotic feeling and are to be distinguished from sexual phantasies of a perverted type associated with sexual excitement. A woman may be obsessed with the

idea that she possesses a penis-like organ which she must control by various forms of inhibiting ritual, but at no time does she experience erotic sensation or realise that her compulsive thought is part of a masturbation system.

Although obsessional patients are seldom aggressive in behaviour, they sometimes give way to compulsive actions of an aggressive type which do not evoke immediately inhibiting affects. The form of delinquent behaviour known as kleptomania is essentially obsessional in type. It must however be distinguished from compulsive delinquencies of a psychopathic type. In the latter case some degree of direct satisfaction is obtained and there are no signs of any counter reactions, whereas in the true kleptomania, although the action may not evoke any guilt response, it is usually followed at a later period by some action of an expiatory nature. Stealing from a shop may be followed by a donation to a charitable object.

Such observations raise the question of classifying obsessions in accordance with the *emotional state* experienced by the victim. That obsessional neuroses are of an extremely 'painful' nature there can be no possible doubt. The compelling nature of the impulse becomes in some cases quite intolerable. In these instances it is not hard to establish that, although apparently the result of a positive impulse, the pain is mainly due to the tension of unconscious frustration. Many of the reactions belong to the guilt group, so much so that *the obsessional neurosis is often described as a guilt-neurosis*. It is to be noted, however, that in many instances guilt does not immediately follow the commission of the obsessive act. It may be experienced at a later phase of the process when the connection with the act has been lost. A certain amount of anxiety, usually of the type of 'social anxiety' is experienced. In such cases the relation to phobia formation is closer. Similarly in anxiety hysteria some degree of obsessional reaction can be observed, particularly in the contamination phobias. Disgust and aversion may also accompany obsessional practices, although, on the other hand, it is not uncommon to find that even painful obsessions may in course of time produce an almost affectionate response. Many patients who abandon their obsessions during treatment complain of a sense of loss, as if an old and well-worn keepsake had been taken from them. Feelings of *doubt* come in a special category. The origin of the doubt is over-determined. As will be noted later, a main factor is the existence of ambivalence in emotional feeling towards objects. The doubt represents an underlying uncertainty whether to love or hate or whether one can love or hate. It also indicates uncertainty over heterosexual as compared with homosexual tendencies, an unconscious doubt about maleness or femaleness of impulse. Finally it is closely linked with early conflict over masturbatory impulse. This is well illustrated in water-tap obsessions. The



doubt 'Have I or have I not left the tap running' can be expressed in the following forms, either 'Have I or have I not masturbated' or 'Shall or shall I not masturbate'. The feeling of doubt is thus a fused affect.

*Etiological Aspects.* Although processes of obsessional symptom-formation follow the standard psycho-neurotic pattern, obsessional neuroses differ from the hysterias in some important aspects. As has been noted the results of faulty repression are more obvious; aggressive and sexual phantasies which would normally be subject to repression sometimes appear openly in consciousness. Again the element of unconscious compromise formation is sometimes openly extended in the diphasic order of the symptoms; the alternation of 'crime' and 'punishment' is not difficult to detect. It is true of course that the 'crime' confessed (acted out) functions as a kind of decoy to distract attention from more important repressed elements, and that the infantile 'date' of the offence is carefully concealed by the suggestion that it has been committed in the present. Nevertheless the break through (return) of the repressed is sufficiently threatening to call for additional measures of defence.

One of these consists in an excessive use of *displacement*, a mechanism which has already been studied in the case of phobia-formation. A symbolic representation of the repressed thought starts the trail of displacement. In the case of lengthy rituals this can be traced through an endless variety of substitutions. As has been pointed out the rationale of the system is to increase the psychic distance between pre-conscious and unconscious derivatives; the manoeuvre fails because of the steady pressure of unconscious cathexis (charge of excitation).

Studying the alternating phases of obsessional symptoms more closely, it becomes clear that an antithetical relation exists between them. An obsessional thought or action is followed by a thought or action calculated to undo or cancel the alleged affect of the original obsession. That there is something 'magical' in the process of *undoing* is suggested by the fact that in many cases the undoing action is merely a repetition of the action. 'Black' magic is followed by 'white' magic, 'bad' thoughts by 'good'. The undoing phase also contains an element of expiation, punishment or sacrifice. The resemblance between 'undoing' and *reaction-formation* whereby, for example, sadistic attitudes are held in check by attitudes of pity and over-solicitousness, is very close. But whereas the effect in reaction-formation is general, undoing is strictly localised and directed against immediate derivatives of the repressed. Undoing accounts for an immense variety of obsessional practices including such forms as obsessional counting, touching, washing, etc.

Returning to the psychic content of obsessional precautions it is to be

observed that these are directed in particular against injury by contamination; in other words the repressed phantasies are very closely concerned with *anal-sadistic derivatives*. It is also obvious not only from the manifest content of obsessions but from their symbolic representation that homosexual phantasies play an important part in the formations. This led Freud to the conclusion that the obsessional neurotic has *regressed* from the infantile genito-sexual (Oedipus) phase to the anal-sadistic phase of pre-genital development, a phase which lends itself readily to the phantasied gratification of active and passive infantile homosexual impulses. In the case of true obsessions, however, this regression is a *defensive regression* intended to conceal repressed genital Oedipus phantasies. This becomes clear when the analysis of anal-sadistic phantasies leads to the break through of genital incest phantasies with or without hysterical phobia-formations. In the more severe cases, however, there are indications that the original infantile genital 'positions' have been weakly held and that a large part of the infantile libido has remained fixated at the anal-sadistic homosexual phase.

In view of these facts it is not surprising that a marked degree of unconscious *ambivalence* in object relations is responsible for many obsessional practices. The obsessional neurotic is unconsciously obsessed by the idea that his love-impulses are destructive, a fact which accounts for the large number of injury ideas and counter-ideas manifested in obsessional thinking and action. By this exaggeration of destructive imagery, the patient succeeds in concealing the infantile sexual nature of his interests. Similarly, exaggeration of openly sexual images is used to conceal the destructive nature of his unconscious phantasies. Here again compromises are common. A man may have the obsessive thought of breaking someone's arm and follow up this concealed representation of castrating a rival by an isolated act of masturbation which has no manifest psychic content. *Broadly speaking every obsessional neurosis is an unsuccessful attempt to cope with an ambivalence to objects, which ambivalence threatens the stability of the ego.*

In this connection it is interesting to note that ambivalence is an heritage from that early phase of development during which co-ordination is imperfect and the baby is at the mercy of a succession of intense 'all or none' feelings and impulsive states. In course of development these violent emotional changes become focused in an alternation of love and hate attitudes to objects. The obsessional tries to cure this unsatisfactory state of affairs, partly by increasing the number of his objects by substitution and partly by compounding or blending his affects. This compounding fails when the feelings in question are too disparate, e.g., when love and hate are too strong and too evenly balanced. The result is a relapse into older states of alternation, now disguised by obsessional rituals of thought and action.

This regression possibly accounts for a special type of obsessional reaction which Freud described as *isolation*. Isolation is the name applied to that process whereby both affective and ideational associations are, as it were, disconnected from the obsessional presentations or whereby different parts of an originally ambivalent attitude to objects are kept apart in time and space. As the result of this process the affect appropriate to an obsessional idea appears in some other context, and the idea in consequence is experienced as an abstraction apparently without emotional value. Nevertheless the existence of obsessional precautions shews that the mechanism does not effect its purpose satisfactorily. In touching obsessions the complete ritual may be *interrupted* at various points in time and place. Counting rituals in particular lend themselves to the process of *dissociation in time*. The exact origin of the mechanism has not yet been determined and it is difficult to exclude the influence of part-repression, aim-inhibition, displacement and other techniques of dissociation.

One of the most remarkable features of the obsessional neurosis is the contrast existing between the, often superior, intellectual faculties of the individual and the child-like play of ideas existing within his obsessional system. Not only is the obsessional part of the mind credulous and superstitious to a degree but the contrasting phases of the neurosis represent a caricature of the relations between a strict and old-fashioned parent and a rebellious but at the same time easily intimidated and guilty child. According to the content of the obsessions, the 'parental figure' watches over the 'child' with a hawk-like eye for infantile misdemeanours, exacting a heavy punishment for every aggressive thought, categorically forbidding the exercise of infantile sexual function, with very special reference to masturbatory impulse, and demanding above all that the child should never be dirty. The 'child' on the other hand constantly provokes this 'parent' to condign measures of talion punishment by staging rebellious demonstrations of infantile impulse life.

It is easy therefore to infer that the ego of the individual has become an arena in which Id impulses and super-ego counter-impulses fight a perpetual battle. The most striking etiological factor in the neurosis is indeed the *archaic severity of the super-ego*. This is explained by the fact that the child's original impulses towards objects have contained a strong aggressive component and have given rise to an aggressive type of super-ego. When, later on, libido is withdrawn and introverted, the sadistic component again attaches itself to the super-ego and increases its already excessive severity. Yet, strange as it may seem, the ego is more concerned with fear of loss of love from this super-ego than with the urgencies of the Id. For although the ego makes constant attempts to effect a compromise between the warring institutions, the neurotic

bent of the individual renders him more vulnerable to loss of love.

The importance of the super-ego factor and of the guilt manifestations to which it gives rise, definitely places the development of obsessional neurosis at a later date than that of anxiety hysteria. Clinically speaking true obsessional neuroses generally appear (or are first recognised) in the latency period. But this fact in no way discounts the importance of the infantile 'obsessional' phase of development. Whereas relatively normal children pass through this phase or fall back on it only occasionally, obsessional children, and of course adults, seem never to have been able to free themselves from pre-genital influences. The determining factor is no doubt a relative excess of infantile sadism.

Using these etiological formulations it is possible to decode with some rapidity the various disguised forms of obsessional activity described by patients at consultation. As has been pointed out cases marked by excessive doubt have unconscious difficulties over ambivalence to parents, infantile homosexuality and masturbatory guilt. The case already described who spent time tying and untying his tie shewed the intensity both of his love and of his hate for his wife but in so doing he repeated his earlier emotional attitude to his mother. The victim of the dusting ritual was in a state of conflict over his passive homosexual phantasies. An obsessional woman who was compelled to pick off pieces of fluff from her clothes and to pull out all projecting threads the number of which was naturally increased by her plucking activities, was at the same time afraid of an incestuous pregnancy, of masturbation and of her antagonism to the (sadistic) penis of her father. Washing obsessions guard against impregnation and masturbatory phantasies of a regressive anal type. Gas-jet and water tap obsessions are also representative of sadistic impregnation and masturbatory phantasy. Ceremonial movements are concerned with phantasies of incestuous intercourse. Obsessive concealment of ritual movements has a masturbatory reference. Killing phantasies combine sadistic and infantile genital coitus elements. Touching rituals are also concerned with sadistic phantasies but have an obvious masturbatory reference. Toilet rituals are based on anal phantasies but have a concealed genital significance. Word obsessions have a strong sadistic component.

*Diagnostic Aspects.* There is seldom any difficulty in recognising obsessional formations. The only problem that arises is to distinguish pure obsessions from those that have a depressive or paranoid background. In the graver forms not only are the obsessions more closely concerned with anal and oral sadistic phantasies but the tendency of the obsession is to spread from a stereotyped channel of displacement to mental activities as a whole or to the total personality; as, for example, when obsessional rituals of a markedly anal-sadistic type spread from

washing and contamination observances to most everyday activities and forms of thought. In such cases the general impression created by the patient is one of paranoidal suspicion. Periods of depression sometimes disturb the more familiar affects of the neurosis.

As in the case of other psycho-neuroses, a careful anamnesis helps to clear up doubtful points in diagnosis and prognosis. In particular a history of earlier phobias formation is a favourable sign. Close examination should be made of the 'infantile obsessional' phase, i.e., the period of infancy when the child's everyday life is subject to ritualistic control. In many instances the character of the patient is also influenced by obsessional patterns of thought and behaviour. The obsessional type suffers from emotional impoverishment, has difficulty in falling in love, varies between excessive orderliness and excessive untidiness, is at the same time over-conscientious and careless, fastidious yet lax, obstinate yet indecisive, in some respects gentle yet frequently inconsiderate, parsimonious yet given to neglect or injury of his own interests.

III. *Mixed Types of Psycho-neurosis.* Although from the etiological point of view clear distinctions can be drawn between the various psycho-neuroses, from the clinical point of view cases of pure neuroses are comparatively rare. Every possible combination of the three main types can be observed in practice. The commonest are (a) conversion symptoms complicating anxiety states, (b) phobias associated with obsessional symptoms, and, less frequently, (c) Obsessional states interrupted by conversion symptoms during the existence of which the obsessional features diminish. Phobias and obsessions with a depressive background are less common but, as has been pointed out, both depressive and paranoidal tendencies may be masked by a severe obsessional neurosis. In still rarer cases where the neurotic symptoms are disproportionately extensive and the integrated personality correspondingly contracted, signs of schizoid reactions may be detected.

In combined conversion and anxiety states it is necessary to detect any hypochondriacal elements suggesting a psychotic substructure. Eating, digestive and intestinal difficulties are sometimes hard to assess in this respect. Although hysterics may shew hypersensitive reaction, their contact is more sanguine, less negativistic, hostile and inaccessible than in schizoid types.

Combinations of anxiety hysteria with obsessional neurosis are the most common. Considering the close etiological relations between the two conditions this is not surprising. Some regard obsessional symptoms as arising in the first instance from a phobic element, but it is also possible to regard the phobia as an anxiety reaction to an isolated remainder from a former obsessional series. Some phobias could justifiably be called 'obsessional'. On the other hand phobias can

sometimes be observed to develop as an auxiliary defence during an obsessional crisis. In the case described above where the patient had an obsessional thought of stabbing with a bread-knife, he developed a phobia of knives, an additional defence against carrying out the stabbing.

During periods of excessive tension obsessional neurotics may also have hysterical seizures followed by an outbreak of conversion symptoms. When this occurs or when some organic illness develops, the obsessional features usually shew signs of remission. Similarly an obsessional neurotic may pass into a period of suspicion during which the obsessional reactions are replaced by persecutory anxiety. During remissions of manic-depression the patient may exhibit obsessional habits. Nevertheless the existence of a true obsessional neurosis is generally a guarantee against psychotic breakdown.

Although there is no great difficulty in arriving at a diagnosis of these mixed states, it is frequently hard to determine what degree of symptom-formation calls for active treatment. As has been emphasised, some forms of anxiety-readiness or phobia formation or obsessional reaction can be detected in most 'normal' people, sometimes a combination of all three. As the practitioner becomes more expert in detecting such minor formations, he tends to recommend treatment without due discrimination. As a rule minor formations can be discounted. An important exception to this rule should be made when the physician has reason to suspect that the whole personality is becoming unstable and that the minor formations are warning signals pointing to an ultimate breakdown. Symptoms occurring during or after middle age are significant in this respect. In any case the prognosis of obsessional neuroses is less favourable than that of hysteria and guarded estimates of the duration of treatment should be given where obsessional features predominate (see Section III). This intractability is no doubt due to the fact that the 'infantile obsessional stage' is the period during which the child first attains some degree of mental stability, and that in consequence the adult, threatened with emotional instability, tends to reactivate and cling to his former 'safety-first' devices.

## Chapter XI

## PSYCHO-SOMATIC AND ALLIED DISORDERS

The student of general medicine confronted with terms such as neurasthenia, anxiety neurosis, hypochondria, traumatic neurosis, organ neurosis, pathoneurosis and psycho-somatic disorder may well be excused some feeling of clinical confusion. And he would not be far wrong if he ascribed some of his difficulties to the muddled state of psychiatric classification and terminology. On the other hand his experience tells him that, apart from the more dramatic forms of conversion hysteria, (paralyses, convulsions and the like) a number of disorders of organic function exist, in many of which 'psychological factors' appear to play a part. These he finds some difficulty in labelling. If the patient strikes him as being a 'neurotic type' he is likely to describe the disorder as a 'neurosis', similar to but not quite the same as a 'conversion hysteria'. If however the patient does not present any 'neurotic' stigmata, as in some cases of peptic ulcer, for example, the physician is inclined to describe the condition under the heading of 'functional disorder', and, for a time at any rate, to treat it as if it were purely 'organic' in nature. Moreover, biased by this training in systematic medicine, he classifies the symptoms present in accordance with the bodily organ or system mainly involved: and this habit constantly prejudices him in favour of organic etiologies. So that even if at first he is attracted by the term 'psycho-somatic disorder' he usually ends either by concentrating on its somatic aspects or, if psychic factors are indisputably present, by regarding these as psycho-neurotic in type.

Some of these misunderstandings can be eliminated by tracing the origins of the terms 'neurosis', 'psychosis', 'psycho-neurosis', 'functional disorder' and the like. But this etymological approach though useful enough in its way, will not fully resolve the student's difficulties. The fact is that no disorder in which 'psychological factors' play a part can be accurately classified unless the function of the mental apparatus is adequately understood; and this involves full recognition of the part played by unconscious forces, mechanisms and institutions. As in the case of purely psycho-neurotic disorders, classification of disorders in which psychogenic factors 'play a part' depends in the long run on etiological understanding.

Following this approach it is possible to draw two fundamental distinctions between the psycho-neuroses and all psycho-somatic disorders, first, that *the process of symptom-formation in the psycho-neuroses follows a standardised psychic pattern* and, second, that *the*

*psycho-neuroses have psychic content and meaning. Psycho-somatic disorders on the other hand, although influenced by psychic reactions at some point or another in their progress, have in themselves no psychic content, and consequently do not present stereotyped patterns of conflict. Should they develop psychic meaning, it may be assumed that a psycho-neurotic process has been superimposed on a psycho-somatic foundation.*

Having distinguished in principle between the psycho-neuroses and psycho-somatic states it is then possible to subdivide the latter in accordance with the psychic factors contributing to them. To do so it is necessary to bear in mind, first, the function of the mental apparatus and second, the various ways in which this function can be disturbed. In both instances the *various stages of development* of the mind must be clearly distinguished, for in both normal and abnormal conditions, the factor of regression to earlier phases is constant. In particular it should be remembered that all mental activities can be arranged in an *excitation-discharge sequence* which may or may not end in motor and sensory innervations. The psychic constituents of this sequence are *affects* and *ideations*. The behaviouristic expressions of tension or discharge are represented by *speech* and *action*. The mind also takes cognisance both of somatic expressions of affect and of the motor and sensory manifestations of behaviour. So that at all stages of the excitation-discharge sequence, psychic and somatic factors are normally in a constant and close state of interrelation.

Now psychic excitation is due primarily to the stimulus of psychic energies: either ungratified instincts acquire a certain head of endopsychic tension which calls for adaptation, or the stress of external (environmental) circumstances is such as to cause instinctual tension and so provoke psychic excitation and reaction. In normal cases this tension is either discharged or controlled. If an instinct is frustrated the energy is distributed in such a way that no pathological consequences ensue: if gratified the result is a normal adaptation. Similarly with environmental stress. In normal cases the ego either corrects the stress, or overcomes it or withdraws from it. *In abnormal cases either the discharge is unsuitable or the attempts to control the energy give rise to difficulties at any point of the excitation series.* Two simple cases may be stated by way of illustration. Either the *internal* (instinctual) *charge* is unduly strong or at any rate too strong for the ego to cope with or the *external stimulus* is too intense for the ego to master in a normal way. In the former case we may have, for example, an *anxiety neurosis*, in the latter a *traumatic neurosis*.

But the matter is not so simple. An external trauma which one individual can cope with, e.g., combatant conditions or bomb shock, may be beyond the compass of another to master. In which latter case



we may suspect that earlier and possibly psychogenic factors are also responsible for the condition. And these earlier factors may be due in turn either to constitutional disposition or to disorders of psychic development. Similarly an anxiety neurosis can be excited by internal disturbances of instinct leading to psycho-chemical changes but it may be aggravated by environment factors such as a state of current sexual frustration either partial or total.

For the moment we may leave these complications out of account. It is sufficient to say that *the psychic element in psycho-somatic disorders brings about abnormal forms of control or of discharge*: and we might conveniently speak of *disorders of excitation and disorders of discharge* that is to say, broadly speaking, abnormalities associated respectively with *early* and *late* stages of the excitation-discharge sequences that give rise to mental activity.

But as the clinician is concerned primarily with symptoms and their treatment, it is desirable to describe these processes in *clinical terms*. For although psycho-somatic disorders are extremely variable and although, unlike the symptom-formations of the psycho-neuroses, they have no psychic content, *they share with the psycho-neuroses certain factors of symptom-formation*. For example, we can speak of psycho-somatic conditions in which the main factors are *constitutional* and those in which they are *precipitating*. And it is convenient to bracket alongside the constitutional factors those infantile (psychogenic) influences that predispose either to the accumulation (damming up) of instinct tension or to the incapacity of the ego to master tension or to discharge it normally.

Although Freud was of the opinion that at some future date it might be possible to reduce psychogenic factors to terms of physico-chemical change, it is clear that even in the case of *constitutional factors* it is not yet possible to do so satisfactorily. In the case of disorders of the hormonal system it is possible to correlate crude changes with certain psycho-somatic manifestations; but the relation of hormonal disorder with vegetative dysfunction is extremely close and their combined influence on other organic systems including the central nervous system gives rise to somatic changes which have not yet been accurately ascertained but which certainly bring psychological dysfunction in their train. On the other hand, simple organic factors such as congenital deformities have notoriously a profound influence on the psychic constitution of the individual. In fact it is a truism that *no physical change or dysfunction can occur without producing some psychic reaction, which, if lasting enough, may in its turn bring about alterations of somatic balance*.

Apart from these general constitutional elements there are a number of more *specific* factors which can be traced back in the last

resort to variations in the strength of the various *components instincts*, and in particular to the *distribution of libido* amongst the various body systems and organs. It is unnecessary to repeat here the theory of component sexuality, its phases of primacy and its organisation in erotogenic zones. But it is obvious that the periodicities of instinct must unconsciously affect organic functions. Also that when an organ serves erotic as well as physiological functions, *any excess of the erotic function will disturb the organic function*. Freud originally pointed this out in connection with functional disturbances of vision but it is easy to see that erotic hyperactivity of 'zonal' areas, mouth, stomach, intestine, arms, skin, etc., can be responsible for feeding and gastric disturbances colitis, constipation and some forms of eczema.

Where in addition to disturbances of erotogenic balance, there is evidence that aggressive reactions have been prominent throughout development, it is reasonable to assume that the organic systems which bear the brunt of aggressive excitations or which ordinarily effect its discharge are subject to excessive physico-chemical changes, e.g., in the appropriate glandular and muscular systems, and so bring about somatic dysfunction. Even in the case of psycho-neurotic symptoms crude changes of this sort can be observed, as when an obsessional neurotic, using muscular rituals of hand-clenching in order to defend against unconscious aggression, brings about callus formation in the fingers or palms of the hand. Similarly rigidities associated with chronic rheumatic fibrositis may be traced in part to a functional pattern of instinctual inhibition.

To these quantitative and qualitative instinctual factors must be added the influence of the *affective derivatives of instinct* on body function. Instinctual hyperactivity results naturally in affective hyperactivity which in turn causes motor and secretory disturbances. The physico-chemical changes consequent on these disturbances may, if lasting enough, produce a permanent change in the somatic function of a given organ. The same applies to affects of a *reactive* type. Primary reactive affects of anxiety, for example, naturally obtain discharge through the circulatory, respiratory, gastro-intestinal, muscular and cutaneous systems and if persistent enough may give rise to cardiac 'neuroses', to forms of asthma, to chronic diarrhoea, to persistent tremors or to some of the dermatoses. It is perfectly proper to call such instinctual and affective disturbances of somatic function *organ-neuroses*; so long as it is remembered that they have no psychic content and are not therefore psycho-neuroses.

What applies to primary affects such as anxiety, applies also to secondary and fused affects. (see Affects). In the first place the anxiety component of unconscious guilt or the residual anxiety associated with guilt permits a direct canalisation of somatic discharge. Secondly through

the amount of inhibition caused by unconscious guilt, the psychic apparatus tends to be flooded with inhibited excitations which may sooner or later affect somatic function. This is true also of more elaborate fused affects such as depression. These disturb organ systems in two ways, first, because the psychic pain associated with object-loss and consequent frustration of impulse can be discharged through somatic channels (this is very obvious in the later and more organised stages of grief): and, second, because the fusion of grief, anxiety, guilt and hate present in organised depression interferes radically with the free discharge of instinct excitations. Hence the common attribution of certain gastro-intestinal 'organ neuroses' to undischarged grief.

So far we have considered psycho-somatic manifestations due solely to constitutional and predisposing factors which by permanently disturbing the excitation-discharge sequence bring about disorders of somatic function. But at this point we can no longer exclude *psychogenic factors due to psychological disturbances of development*.

To give a simple example, it is obvious that if a child becomes fixated to a particular phase of infantile erotic relation to an object, the factor of *psychic fixation* will of itself set up both quantitative and qualitative changes in instinctual tension. An oral-erotic type, for example, is certainly more liable to gastric disturbances, an anal erotic type more liable to intestinal and anal disorders than a person whose oral and anal erotism has not been grossly accentuated by relations with oral and anal objects. This however does not imply that the disturbances in themselves have psychic content. *The influence of psychic content is exerted only when these infantile vicissitudes of instinct have given rise to mental conflict*. For obviously mental conflict is likely to affect charges of instinct in the direction either of hyperactivity or of inhibition. And as has been indicated the somatic consequences of inhibition are just as important as those of hyperactivity.

At this juncture the student might well maintain that, such being the case, there is no point in endeavouring to distinguish between psycho-somatic conditions and psycho-neuroses. He might argue that since psycho-neuroses are due ultimately to the reactivation of infantile conflict, all manifestations of unconscious conflict must be psycho-neurotic. Although natural enough views of this kind are due to a misunderstanding. Psychic conflict although varying in degree is universal: on the other hand only a comparatively small percentage of the population develop true psycho-neuroses. The psycho-neuroses are specific reactions to the breakdown of repression and the return of the repressed. An anxious type is not an anxiety hysteric. Yet, for example, he may have experienced so much unconscious fear of castration during childhood that he is unduly concerned with the function of any organ symbolising the male genital. In the case of visual disturbances, the eye (and its

functions) may be reacted to as if it were a penis. And this undue concern will not only disturb the narcissistic valuation of the eye but disturb its economy of organ-libido and if persistent enough may cause disorders of visual function. A hysterical phobia of blindness, on the other hand, or actual attacks of hysterical blindness may be associated with normal physiological function of the eye; in other words, no psychosomatic disturbances may be present.

All this may be summed up theoretically by saying that *organic functions can be upset by mental defences which set up permanent instinctual imbalance, either in the form of increase or reduction or again of frequent and violent fluctuations of excitation.*

From the clinical point of view the importance of these psychogenic elements in psycho-somatic disorder cannot be over-estimated. Not only do they provide some basis for classification, but they offer the psychotherapist his most effective avenue of approach. In short although there is no objection to the use of the term 'organ neurosis', it is much more satisfactory to classify these conditions in etiological terms. For example, individuals whose defences against *unconscious homosexual libido* have been strongly reinforced since childhood may exhibit a variety of organ-neurotic disturbances, the more so if there has been an excess of pre-genital over genital libido. These may take the form of hormonal disorders which in turn produce secondary psycho-somatic changes. Or they may give rise directly to various forms of gastritis with or without ulcer formation, to colitis or spastic conditions of the intestines, to constipation or diarrhoea, to muscular hypertonus or hypotonus followed by the various symptomatic accompaniment of 'dropped' organs, to tachycardia with or without hypertension, to some erythemata and to a variety of hypochondriacal disturbances. Where the sadistic element of the homosexual complex is exaggerated the muscular dysfunctions are usually excessive, sometimes also respiratory disorders. Sleep too is usually disturbed.

Where one particular organ or system is the seat of election for psycho-somatic disorder, more specific localising factors should be looked for. As has been pointed out the influence of *oral erotic* factors is decisive for *gastric disturbances*. This is due not solely to the fact that oral erotism is constitutionally strong or that it has been accentuated during the process of infantile development, but to the fact that infantile love and hate relations to objects have been strongly influenced by oral elements. Frustration instead of being felt in terms of genital anxiety or sadism is experienced as oral loss or as a kind of perverted hunger (*cf* loss of appetite or *bulemia* following loss of a love object), which sets up gastric disturbances such as hypersecretion or hyposecretion and ends in the development of peptic ulcers.

*In respiratory disorders of the asthma or bronchial asthma type a*

variety of psychogenic factors operate. Respiratory erotism and aggression are usually enhanced and a good deal of displaced oral sometimes of urinary erotism is present. Pre-genital as well as genital anxieties play a considerable part and a sado-masochistic factor is usually found. Some observers indeed regard bronchial asthma as a kind of pre-genital conversion.

In *cardio-vascular conditions* three main factors predominate. Anxiety readiness is a marked predisposing agent, but genital anxieties and guilts are constantly present. Inhibition of aggressive impulses constitutes the third factor: it is present also in cases of essential *hypertension*.

Closely associated with cardio-vascular neuroses are the various *skin neuroses*, in particular blushing. But here as in the various sweating disorders, dermatographias and other signs of vegetative irritability a strong factor of exhibitionism complicates the other erotogenic elements. Displaced genital anxiety is also present.

The above examples by no means exhaust the varieties of psychosomatic disorder in which psychic developmental factors play a part. Indeed there is hardly an instinctual or affective expression of a defensive kind which cannot lead to some form or another of psycho-somatic disorder however trivial. Thus some anxiety types may express their prevailing mental reaction in the form of a nervous cough and end by developing an essential emphysema. Another may develop a scratching habit, pick at a scar and produce granulations requiring constant surgical attention.

It remains to consider the last of the factors common to both psychosomatic conditions and psycho-neurotic states. This is described as the *precipitating factor*. It is best illustrated in the condition previously referred to as a *traumatic neurosis*, where external or environmental stress develops of a nature sufficiently drastic to damage the ego's capacity to maintain effective instinctual economy. A moment's consideration will shew however that even here psychological factors e.g., the state of the mental apparatus and the unconscious disposition of the individual cannot be excluded. Indeed with a few exceptions, such as unavoidable accidents, and these fortuitous traumatic events sometimes described as 'acts of God', the purely accidental nature of the environmental stimulus does not bear too close inspection. To be mauled by a tiger may seem a purely accidental occurrence but to the tiger hunter it is as much a professional risk as 'shell-shock' to a professional soldier: the jungle jay-walker can scarcely maintain that his injuries were 'purely accidental'.

In any case not all precipitating factors are purely environmental. *Any marked change in libido economy can set up a state of instinctual stress leading to disturbances of a psycho-somatic type.* This is well

illustrated in the somatic manifestations of anxiety appearing at puberty, adolescence, middle age, and during climacteric phases; also in various neurasthenic and hypochondriac symptoms occurring during 'critical' phases of libido development and regression.

Yet another type of precipitating factor is represented by the rapid development of serious *organic disease*. This operates in two ways, through the disturbance of narcissistic economy and through the disturbance of organ libido. These changes can either produce psychosomatic disturbance or bring about a kind of artificial 'somatic compliance' laying the individual open to neurotic exploitation. Some writers reserve the term *pathoneurosis* for conditions in which neuroses are a consequence of somatic disease.

Before describing some of the more complicated psycho-somatic conditions that are met with in everyday practice it is convenient to summarise briefly the main etiological differences between these and the classical conversions. In the first place conversion phenomena are expressions of psychic conflict having a specific psychic content, representing compromises between the opposing sides of the conflict; they are governed by fixed unconscious mechanisms, possess a distinct pattern and develop along psychically predictable lines. At all times the relation of the symptoms to the ego is precise. Psycho-somatic symptoms although sharing with the psycho-neuroses some of the processes of symptom-formation have no specific unconscious content. They can be brought about by any disturbance of mental economy which influences somatic function. The channels by which this influence is exerted vary widely and the interrelations between psychic and somatic factors are also variable. Hence their relation to the ego is also extremely variable. Psychic factors can bring about somatic changes which in turn produce secondary psychic reactions and therefore in course of time secondary somatic changes. Similarly somatic factors can bring psychic reactions which in turn produce secondary somatic changes.

The nature of the psychic factors varies according to the level of mental function operating in each case. Generally speaking, undue increase, decrease or fluctuation of excitation produce somatic changes not only directly but through the attempts of the mental apparatus to control the pathogenic situation. Old standing patterns of ego-conflict can bring about conditions of stasis, inhibition, excessive discharge and various defensive affects which then disturb somatic function.

Two further points are relevant: first, that the incidence of psychosomatic diseases is much greater than that of the psycho-neuroses and, second, that nevertheless in some cases difficulties in differential diagnosis arise. These are due either to the development of secondary but true psycho-neurotic symptoms or to the exaggeration of particular

conflict-patterns, e.g., in unconscious homosexuality, masochism and the like. Although in most cases a sound clinical distinction can be effected, it is sometimes impossible to draw a hard and fast line between the conditions. A good example of the difficulty is presented by the traumatic neuroses.

*Traumatic Neuroses.* Study of the clinical material to be observed in war neuroses, accident and other 'traumatic' states establishes two points of significance, first, that the pathogenic force of the trauma varies widely and, second, that neither the term 'neurosis' nor for that matter 'psychosis' is adapted to describe the clinical manifestations. There is no quantitative criterion of mental stress. Traumata vary in their effects in accordance with constitutional and developmental factors and with the immediate condition of the mental apparatus. Infantile fixation and habit, fatigue, exhaustion, worry, emotional loss, limitation of motor freedom during the trauma, unexpectedness of the trauma and unpreparedness for it all produce characteristic variations. Nevertheless the clinical symptoms indicate that, whatever the nature of the 'injury', a *traumatic factor of psychic stress* is decisive for the condition.

The symptoms most frequently observed fall into two groups, (a) states of acute anxiety and/or pain, expressed either in physical or in mental form, and (b) various inhibitions of physical function which in turn are closely connected with pathological varieties of fatigue and exhaustion. The first of these two types is at the same time a sign of increased tension and an attempt to discharge it; the second is at the same time an attempt to inhibit the development of any further tension and to protect against too violent discharge. The nature of the somatic symptoms varies according to the proportionate strength of these two main types of reaction. In the 'discharge' group anxiety symptoms of an 'irritable' type affect heart, lungs, gastro-intestinal and muscular systems. In the 'inhibited' group the ego attempts to 'seal itself off' from further stimulation by inhibition and regression of function. Hence in part the exhaustion and irritability that follow effort of a purposive kind. Mental manifestations can also be divided into agitated and inert types. In the so-called confusional states, apart from gross disturbances of memory and orientation, changes in psycho-sexual function (impotence) and in the personality (irritability and negativism) occur which can be attributed respectively to inhibition of function or excessive discharge of tension. Disturbances of sleep are common, during which attempts are made at spontaneous cure by repetition of the traumatic setting e.g., the 'trauma'-dream.

Following the example of organic physicians, who are in the habit of labelling disturbances of organic function, in which no manifest symptoms of organic disease can be found, 'functional disorders', we

can describe cases of this kind as '*functional disorders of the mind*', implying thereby that they represent attempts on the part of the psychic apparatus to redress an abnormal (traumatic) balance of excitation, using for the purpose the various mechanisms of inhibition, distribution and discharge of instinctual excitations. Some confusion may arise from this terminological usage: but it is offset by the advantage of distinguishing between on the one hand disturbances of psychic excitation and discharge and on the other, psychic symptom-formations having specific mental content.

In a number of instances psycho-neurotic symptoms, (anxiety phobias and hysterical dissociations) may make their appearance. In rarer instances the symptoms of confusion, inhibition and retardation may be hard to distinguish from a schizophrenic regression or other psychotic reaction. In such cases the influence of infantile psychogenic factors is unmistakable: the psycho-neurotic symptoms are in fact true neurotic formations superimposed on a psycho-somatic state which has reduced the efficiency of repression: the psychotic reactions are induced by the action of the trauma on an already unstable and narcissistic ego.

By way of contrast a number of manifestations occur which although determined by infantile psychic disposition and defences are neither psycho-neurotic nor psychotic. *Regressions to infantile behaviour* – in gait, speech, mannerisms, feeding habits, scenes of violence and rage etc. – represent attempts to attain a state of infantile (pre-traumatic) security, and at the same time to discharge the pathogenic tension at an earlier (infantile) level; and it is significant that the constitution of individuals prone to traumatic neuroses is either markedly infantile or (in the unconscious sense) markedly homosexual. This is very obvious in cases of war-neurosis where the patient is unable to endure the infantilism of army life. In the combatant neuroses there is of course an additional factor to contend with, viz., *defence against repressed sado-masochism*. This is responsible for the more crippling symptoms. In the accident neurosis the significance of the injury depends partly on the constitution of the individual which is usually narcissistic and partly on the symbolic value of the part affected. Castration anxiety is readily mobilised by injuries to head or limbs whereas internal injuries reactivate pre-genital anxieties.

While it is easy to recognise traumatic neuroses in which the environmental (precipitating) factor is of a dramatic nature, should the conditions of trauma be cumulative (as in recurring illness or repeated operations) or should the trauma be purely psychical (as in loss of a love-object), the development of a traumatic neurosis may go undetected. Many of the obscure anxiety states with hypochondriacal and neurasthenic symptoms occurring in middle and late middle life are really traumatic neuroses in which the precipitating factor is not



immediately obvious. Unconscious intimations of decreasing potency or simple dread of impotency acts as a traumatic stimulus and produces both anxiety reactions and excessive inhibitions which have then to be justified by the patient on the score of physical ill-health and exhaustion. Perhaps the most interesting variety of traumatic neurosis is that found in childhood as the result of emotional change in the family setting e.g., 'evacuation' neuroses. Allowing for difference in the idiom of discharge, the symptoms appearing in such traumatic cases are identical with those observed in adults, increased anxiety discharges, increased inhibition, disturbances of function, (sleeplessness, bedwetting, stomach and bowel disorders) pilfering, truanting and outbursts of rage and violence.

It is in keeping with the functional nature of these disorders that the factor of *gain through illness* (secondary gain) is more obvious in the traumatic neuroses than in the case of the psycho-neuroses. There are a number of psychological reasons for this of which the most important is that the element of unconscious guilt present in the psycho-neuroses is not immediately mobilised: hence the compensatory aspects of the regression in traumatic neuroses are all the more obvious. Behind many of the outbursts of rage lies a sense of persecution which though not clinically psychotic lends itself to the development of compensation neuroses. Here again a factor of conflict over infantile aggression will be found operative.

*Anxiety Neuroses.* The closer one examines the traumatic neuroses, the more difficult it proves to draw a hard and fast theoretical distinction between them and the conditions known as anxiety neuroses, neurasthenia and hypochondria. And this in turn suggests that however much they may differ all of these conditions have in common some of the factors that cause functional disturbance of the psychic apparatus. In the case of the *anxiety neurosis*, which until Freud's time was included under the general caption of neurasthenia, the common factor is easy to detect, namely the flooding of the mental apparatus with libidinal excitation which the ego is unable to control or discharge by normal procedures. The increased excitation is partly *expressed* in anxiety and partly, though irregularly, *discharged through* anxiety manifestations. The characteristic feature is therefore a great increase in anxiety readiness. Anxiety appears to develop even without cause and may develop into panic. This sometimes occurs at regular periods as when an adolescent suffered for a year or so from an hour of horrible dread almost every day at twilight. The anxiety is often accompanied by irritability, moodiness and disturbed or restless sleep with continuous anxious dreaming. The irregular discharges of anxiety manifest themselves in disturbances of the cardiovascular, respiratory, gastro-intestinal and

cutaneous systems. In some cases the 'pseudo-toxic' nature of the manifestations give to rise to a mistaken diagnosis of 'alimentary toxæmia', early tuberculosis and kidney infections. These 'toxic' manifestations are somatic 'affect equivalents'.

In adults of both sexes symptoms of this type are often found in association with conditions in which sexual excitement is combined with inadequate sexual gratification, as during the more ardent phases of courting of long-engaged couples, or following the practice of coitus interruptus. In simple cases of this sort relief can be obtained by the pursuit of more rational sexual hygiene, either the avoidance of situations of excessive stimulation or the practice of normal coitus. And in principle there is not much to distinguish such cases from traumatic neuroses, except the fact that in the anxiety neuroses the element of 'cure by repetition' is absent. But in a large number of instances anxiety neurosis is secondary to endopsychic factors (conflict-defences) which lead to damming up of libido and consequently to the development of frustration anxiety. A distinction is made by observing the nature of the ego reaction to anxiety. In the psycho-neuroses the anxiety caused by reactivation of repressed charges (the return of the repressed) operates as a signal to which the ego responds by mobilising unconscious defence mechanisms leading to the compromise symptom-formation. The amount of anxiety unsuccessfully controlled then leads to a *psycho-neurotic repetition* of the defences. In the anxiety neuroses the dammed up libido is *directly expressed in the anxiety manifestations*. The situation is not stereotyped and the reaction of the ego is a mixture of attempts simultaneously to control excitation (hypomotility and anxiety) and to discharge it (anxiety leading to vegetative irritability, etc.). It varies directly with the state of damming-up, whereas the psycho-neurotic symptom varies with the fault in repression.

The distinction between traumatic neurosis and anxiety neurosis is not so important as that between anxiety neurosis and psycho-neurosis. This is harder to effect when the 'conflict-defences' are sufficiently strong as to have already produced an excessive psychic reaction. Nevertheless the vital test is that of faulty repression. A diagnosis of true anxiety neurosis or of any other form of 'actual neurosis' is justifiable only when there is no gross evidence of conversion hysteria or of true phobia-formation. In practice the fact that symptoms may disappear after the institution of normal sexual hygiene does not provide a universally valid criterion. It is good practical policy to regard floating anxieties as a sort of penumbra to real anxiety hysteria.

*Neurasthenia.* Although in the traumatic neurosis the factor of excessive stimulation from without and in the anxiety neurosis the factor of excessive endopsychic stimulation are responsible for some of the

characteristic differences, it is not possible to effect further distinctions on the basis of the 'conflict factor'. The influence of pre-existing unconscious conflict seems to operate equally in both cases. In true neurasthenia however the situation is different. Although a functional condition due to lack of balance between excitation and discharge there is some reason to think that conflict factors are responsible for its characteristic clinical features.

While neurasthenic disturbances can be either acute or chronic, the characteristic features can best be studied in chronic forms. Symptoms of an inhibitory type on the whole dominate the clinical picture but are either blended with or alternate with symptoms expressive of mental tension. The two main features are chronic fatigue and a condition which can best be described as 'fatigue-readiness'. This latter state has a not insignificant resemblance to 'anxiety-readiness' (q.v.). The accompaniments of this chronic fatigue vary. They generally include lack of interest, of capacity for concentration and of initiative. This apparent apathy, indifference and weakness of purpose gives a general impression of what was once called chronic mental impoverishment. Only the simplest activities are embarked on with any chance of success, a fact which suggests that regression is one of the operative psychic mechanisms. On the other hand moodiness may be combined with hypersensitiveness and irritability in which case muscular hypotonus may alternate with rigidity. Hypochondriacal sensations are frequently experienced and various somatic symptoms are complained of which are sometimes mistaken for disorders of metabolism. Some of these are simple discharge phenomena (tremors, headaches, pressure on the top of the head, 'spinal irritation' or pain, some paraesthesias, sometimes diarrhoea): others are due to inhibitory mechanisms, (spastic conditions of the cardiovascular and alimentary systems): others again prove on examination to be mild forms of organ neurosis. Sleep is generally disturbed.

In the more acute forms both psychic and somatic expressions of anxiety are present and although the neurasthenias and the anxiety neuroses are frequently contrasted there is no doubt that in acute phases at any rate they have certain features in common. The progress of the condition varies. With younger people it may persist for some years as a chronic neurasthenia with sub-acute exacerbations, but in some cases symptoms of a traumatic neurosis may supervene; and, as with the anxiety neuroses, a true psycho-neurotic construction may be superimposed on a neurasthenic foundation. Mixed conditions in which neurasthenic and anxiety neurotic symptoms alternate and are complicated by mild organ neuroses, a degree of hypochondria, some traumatic symptoms and some phobia formations having a rather persecutory background can be observed in middle-aged persons, usually males.

The fact that a history either of compulsive masturbation or of excessive conflict over normal masturbation (current or infantile) is so frequently obtained in cases of neurasthenia led to the formulation that the condition was due to lack of balance between psychic need and somatic discharge, the masturbatory stimulations being carried to excess without adequate psychic elaboration. In fact it became the custom to contrast this condition with the excessive psychic excitation and insufficient somatic discharge present in anxiety neuroses. A number of considerations suggest however that the existence of unconscious conflict plays a considerable part in neurasthenia. Certainly neurasthenic symptoms can be greatly reduced by appropriate analysis of unconscious guilt. Moreover the unconscious factors uncovered are very similar to those found in the obsessional neuroses viz., strong homosexual fixation, regression to anal-sadistic levels and conflict over aggression. So close is the connection that many obsessional states are wrongly diagnosed as neurasthenia. Following this hint we may assume that in true neurasthenia the apathy and lack of interest are due to a considerable extent to an absorption of psychic energy in unconscious conflict, also that many of the excitation and discharge phenomena are caused by 'conflict-defences' interfering with normal function. Excess of pre-genital and sadistic elements greatly increase this factor of interference.

*Hypochondria.* A still more intricate form of functional disturbance is that known as hypochondria. This can be manifested either as hypochondriacal anxiety, e.g., when the patient has constant but groundless fears concerning the 'condition' of his body organs, or as hypochondriacal sensations, in which case he complains of pain or other disturbing sensations ('congestions', 'contractions', 'contortions', 'spasms', 'changes', 'alterations', etc.) in one or other of his organs.

Some idea of the elaborate etiological formulae necessary to extend this state can be gathered simply by noting the clinical conditions with which it is associated or which it ushers in. It is observed (1) often in the early stages of an organ-neurosis, (2) less frequently in traumatic neuroses, (3) commonly in anxiety neurosis and (4) neurasthenia: it may proceed or accompany (5) a conversion hysteria or anxiety hysteria, in the latter case usually in the form of hypochondriacal anxiety: and it is to be found (6) in various psychotic states, e.g., in some mild forms of depression heralded by gastro-intestinal disorders, in delusional forms of melancholia, in involutional melancholia and in schizophrenic and paraphrenic attacks of which indeed it may be the first symptom.

We may assume therefore that hypochondria can be caused by the same functional disturbances of excitation and discharge as have been described for each of the first four groups. Having eliminated these we can then concentrate on the mechanisms involved in the psychoses and

in those rarer 'traumatic neuroses' in which psychotic symptoms are manifested. In the first place we can take for granted not only that 'conflict-defences' are responsible for the appearance of hypochondria before or during the psychotic manifestations, but that the factor of regression within the psychic apparatus plays a more important part than it does in the psycho-somatic conditions so far described. In short we must realise that at different stages of the development of the psychic apparatus there are increasingly complicated modes of dealing with excitation. In the earliest stages of mental life the association of stimulation with somatic discharge is closer than at any other time. But as the mind grows the process of regulation is increasingly controlled by psychic factors, until a point is reached at which psychogenic disturbance of unconscious cathexis is the main cause of disorder in the excitation - discharge sequence.

Six concepts are necessary for the understanding of psychotic hypochondria:— (a) organ or body-libido (b) narcissism, (c) the early form of the ego, the so-called 'body-ego', (d) cathexis of instinctual objects, (e) abandonment of object cathexis, (f) regression. Organ libido introduces a basic quantitative factor. The amount of organ libido varies: it can rise above or fall below normal limits. The early formation of ego nuclei within a primary narcissistic organisation depends on corporeal experience of motor and sensory innervations and of motor or sensory expressions of affect which vary with the rise or fall of instinctual excitation. These corporeal experiences also vary with fluctuation in the physiological and erotogenic activity of the organ concerned so that the early nuclei of the ego are 'body nuclei' contained as it were within a skin nucleus. These constitute the first internal differentiations of narcissism but as recognition of objects increases, the narcissistic phase gives place gradually to a phase of distinction between the ego and its objects. Differentiation of objects is heightened by experience of different degrees and kinds of object cathexis.

*But as none of these developments is total and permanent, the processes can always be reversed in a state of regression.* The first stage of this regression in the psychoses is a withdrawal of object libido which however is more wholesale than in the case of neurotic introversion. The psychic object or *imago* is abandoned. Libido regresses to narcissistic levels and lights up in reverse order the various stages of organisation which once led to the development of object formation. To begin with, the ego is flooded with narcissistic libido. Should the regression continue unchecked the original (nuclear) body ego is affected and its earliest and most important nuclear components are overcharged with libido. *At this stage the full force of the functional psycho-somatic process comes into effect.* Organ libido is increased from both direct and indirect sources and disturbance of somatic function commences. This

disturbance is constantly increased by secondary narcissistic cathexis due to anxiety. The early stages of the disturbance give rise to hypochondriacal anxieties and sensations.

In a sense therefore it may be said that a psychotic hypochondria is simply an early manifestation of organ neurosis due to a psychotic regression and that it is complicated by a traumatic element due to narcissistic flooding. But of course it is essential to remember that organ neuroses and traumatic neuroses are not in themselves psychotic. They can only become part of a psychotic system if the ego-organisation is potentially psychotic.

Having isolated the factors leading to psychotic hypochondria, it is comparatively easy to indicate what induces hypochondria in some cases of psycho-neuroses. It is the factor of introversion following withdrawal of object libido which first sets up regression of libido within the psychic apparatus and causes damming up of excitation. When in addition repression fails and unconscious cathexes are freed the flooding reaches a point at which defence is essential. For the most part this is attempted in the form of psycho-neurotic symptom formation. But the overexcitation also gives rise to functional forms of inhibition and discharge, the more so if psycho-neurotic anxieties (e.g., the fear of castration) are displaced from genital images and symbols to organ representations. Where the psycho-neurotic damming up is combined with an increase in anxiety and guilt due to excessive sadistic charge, the attempt to displace from erotic to non-erotic organs is accelerated. In either case a hypochondria can usher in and accompany the psycho-neurotic process.

*Disturbances of Sleep.* As the distinction on the one hand between different forms of functional disturbance and on the other hand between functional disturbances and psycho-neurotic or psychotic constructions becomes clearer, it is possible to indicate more specifically the theoretical basis of these differentiations. One must think always in terms of the mental apparatus and of its psychic hierarchy of functions. In the earliest post-natal stages it has little or no structural organisation: it is a primitive apparatus in which psychic charges (cathexes) move swiftly forward towards motility, discharging themselves either adequately (to the extent that the environment caters for the infant's instinctual needs) or inadequately (in the motor and sensory innervations caused by frustration affects). Excitations that cannot be gratified or discharged return rapidly to the Id: in other words cathexis is withdrawn, perceptual awareness is unstimulated and the charge turns backwards to the point where the infant falls asleep. Primary regression is established. Even this regression varies in depth. It may pause on the preconscious side of awareness to light up memory traces of

perceptions. In the hallucinatory phenomena of this phase we have the raw material of dreams.

Further development of the mental apparatus depends on instinctual vicissitudes, on the recording of pleasure-pain experiences, on the influence of increasingly complicated mechanisms for controlling instinct, on the gradual development of ego-object distinctions, the laying down of ego-nuclei, the development of reality-sense, and of 'controlling' institutions within the increasingly elaborate ego. These different phases are not laid down in distinct superimposed layers. If, to pursue a spatial metaphor, we were to make serial sections of the mental apparatus at different stages we would find that although for the first two years it functions mainly as a compensating balance set in action by the rise and fall of instinct-quantities, nevertheless it becomes increasingly organised.

But the acid test of mental organisation is the development of differentiations within the ego. *Not until the effective control of instinct is achieved by distribution between the ego and the super-ego (however rudimentary) can we speak of endopsychic conflict.* And it is the particular method of dealing with quantitatively excessive endopsychic conflict that lends their characteristic features to the psycho-neuroses and to the psychoses. The ego-organisation, defect of which is responsible for the psychoses, is much more primitive than that responsible for the psycho-neuroses. And we would accordingly expect functional disturbance of the mental apparatus to be much more obvious in the psychoses than in the psycho-neuroses, as indeed it is. Similarly we would expect that even in advanced stages of development earlier systems of discharging tension would continue to function, as indeed the mere continuance of dream formation in adult life conclusively proves. If the analogy were not too rigid and static we could think of the fully developed mind as a palimpsest of systems. The phenomena of regression warn us however to avoid such inelastic metaphors. If we were to borrow an image from organic embryology the function of the developed mind would correspond more to an adult organic structure in which however gill clefts, caudal appendages, thymus glands, and Mullerian ducts all preserved an immediate and effective function of adaptation.

Even this distinction between stages when the psychic apparatus functions on the whole without endopsychic conflict and stages when on the whole the systems that produce conflict play a leading part in the regulation of excitation is not sufficient for clinical purposes. There are transitional stages when functional defences and conflict-defences share the task of controlling instinct and adaptation. So that in apportioning the role of endopsychic mechanisms in psycho-somatic states we must take into account (a) whether ego differentiation is sufficiently

advanced to lead to the use of psycho-neurotic (and psychotic) formations or (b) whether, even if it should be so advanced, the conflict factor may nevertheless merely intensify functional attempts at control.

Proof of the validity of this serial and developmental approach to the problem is afforded by observation of the *disorders of sleep*. Of these the commonest is reduction of sleep (e.g., difficulties in falling asleep, waking up early and frequent waking spells throughout the night) which may increase to the point of insomnia. Disturbances may be associated with motor habits, enuresis or somnambulism. Excluding the various organic causes, disturbed sleep is found to have roughly the same clinical distribution as hypochondria. It is present in neurasthenia, anxiety neuroses, and traumatic neuroses, in the psycho-neuroses and the psychoses. The most striking disturbances are observed in the traumatic neuroses and the most marked insomnia in the depressive states and involutional melancholias, although the insomnia of some anxiety states may be very striking indeed.

Study of these conditions and in particular analysis of terror dreams occurring in *pavor nocturnus* and in traumatic neuroses shews that, as might be expected, the factors concerned are (1) the *source* of the excessive stimuli, (2) the *level* of the stimulation and (3) the *mechanism employed* for dealing with the stimulation. These last also vary according to level. Functional methods of discharge may be employed as in the discharge dreams of traumatic neuroses; or the mechanisms of psycho-neuroses and psychoses may be employed. Incidentally it does not follow that these different methods of discharge succeed in *overcoming* the sleep difficulty. On the contrary they are usually responsible for the disturbed sleep.

The nature of the earlier levels of sleep disturbance can be readily inferred from the sleep-habits of infants. The disturbing influence of hunger stimuli and at a later stage of anxiety of separation from protecting objects can be expressed respectively in terms of actual over-stimulation (hunger-frustration) or over-stimulation by anxiety in consequence of a threat of frustration. Comparing these with other sources of disturbed sleep, e.g., postural discomforts, organic diseases etc, we can divide the sources of stimuli into external (sensory, environmental) and endopsychic (instinctual excitation). In passing it should be noted that in the case of separation anxiety, the perceptual factor (presence or absence of object) operates through the instinctual crisis it excites. Naturally external factors may disturb sleep at any point but they usually interfere with the process of falling asleep. Similarly with libidinal and anxiety tensions: these usually disturb falling asleep. Early waking is more commonly associated with deeper endopsychic conflict especially over an excessive excitation of the aggressive impulses.



Study of the disturbances of sleep in the traumatic neuroses shews that, except in cases where marked psycho-neurotic or psychotic reactions appear, the main factor is a state of dammed up excitation which the mind tries to deal with along a functional level. These attempts at discharge (terror-dreams) themselves disturb sleep. So that there are two reasons for the sleeplessness in such cases. In most instances a clear distinction can be drawn between the over-stimulation in traumatic neuroses and in psycho-neurotic and psychotic sleeplessness. In the last two instances the excitations are due to reinforcement of unconscious cathexes. This is most obvious in cases where acute anxiety is aroused and after some absorptive anxiety-dreaming causes the patient to wake up. Up to a point the dream protects sleep but if the hypercathexis of conflicting latent content increases it is unable to do so any longer.

But not only is sleep liable to be disturbed by conflict of a psycho-neurotic type, the process of symbolism which plays a part in psycho-neurotic symptom-formation also results in a condition in which sleep is disturbed, feared or avoided because it symbolises death (either of the self or of parents), castration, orgasm, the time for impregnation, the time for forbidden sexual thoughts and activities (masturbation, seminal emission), the time of parental coitus (primal scenes). In this way an effective *phobia of sleep* can develop. Similarly the preparatory sleep rituals of obsessional neurotics indicate that the state of sleep has come to represent death or incestuous crime of a pregenital type. In the manic-depressive group disturbances of sleep indicate a still deeper level of libidinal and aggressive excitation. In such cases there is still more profound dread of sleep as the time for murder.

The position of bed-wetting and indeed of most sleep-walking (somnambulism) is of special interest. Generally speaking it is possible to distinguish two types one in which the actions are discharge actions of a functional type and another which might be called psycho-neurotic in type, i.e., the actions dramatise an unconscious hypercathexed phantasy in which a compromise element of denial is present. Actions similar to those of waking life deny the unconscious symbolism which has become attached to them and at the same time express it. In this connection it is interesting to compare somnambulism with hysterical dream states, disturbances of consciousness etc. in which the process is seen in reverse. Waking life is disturbed by phantasy or alternatively waking actions are reacted to with anxiety as if they were (guilty) sleep actions.

Similarly excess of sleep (organic causes always excepted) can be usefully compared with the pseudo-stupors of hysteria and with actual psychotic stupors. This correlation is however too crude: the hypersomnias and disturbances of consciousness are capable of layering in

the same way as other sequelae of psycho-somatic or of purely psychogenic states. In short there are a number of levels of sleep disturbance which can be roughly subdivided as follows: (1) primitive functional (2) later (organised) functional (in which conflict-elements are also found) (3) conflict levels without symptom formation, and (4) levels at which symptom formation (Freud) occurs : (a) psychotic (b) psycho-neurotic. Naturally various combinations of all four groups exist.

In every psychiatric classification, indeed in most of the main subdivisions of any psychiatric classification, space must be left for conditions which can be variously described as 'mixed' or 'transitional' types, perhaps better left 'unclassified'. The difficulty in placing such conditions is due sometimes to lack of precise etiological information, sometimes to the fact that the clinical manifestations resemble those observed in other 'classified' psychopathological states. In the conditions so far described in this section it is possible to isolate certain functional defects in the psychic apparatus due to over- or under-stimulation. These defects produce characteristic somatic symptoms. We can see also that as the mind becomes more organised and differentiated conflict factors begin to play a more decisive part in increasing or inhibiting excitation and so add their quota to the psycho-somatic manifestations. Superimposed on these are to be found accretions of a true psychotic or neurotic type, i.e., symptoms that develop under the specific laws of 'symptom-formation,' (Freud).

There are, however, a number of conditions in which the factor of 'symptom-formation' is so marked that at first sight they appear merely to be special varieties or mixed types of psycho-neurosis. Despite these resemblances their clinical form, course and reaction to treatment is quite distinct from those of the psycho-neuroses. Closer inspection shews, moreover, that they share some of the characteristics of functional disorders, in particular of the traumatic neuroses. Hence without prejudice to their ultimate classification it is convenient to consider them in the present section.

*Tics.* The most fascinating example of an unclassified condition is that commonly described as tic. Indeed the simplest attempt to define a tic compels the reader to take sides on the question of its etiological determinants. Some authors get over this difficulty by distinguishing *psychogenic tic* from other forms of *habit-spasm*. Others maintain that whatever psychogenic factors may affect the superstructure of a tic, it is basically an organic reaction due to cortical and sub-cortical irritation of a markedly constitutional nature. More detailed definitions are influenced by one or other of these conceptions. Thus tic is sometimes rather cautiously defined as a stereotyped activity of a group of

voluntary muscles acting independently of an immediate organic neuromuscular stimulus; sometimes it is described quite bluntly as an involuntary co-ordinated movement of psychic origin.

Clinical correlations are even more complicated. The relation of tic to *conversion hysteria* is indicated in the term applied to it by some psycho-analysts viz., 'pre-genital conversion'. This is intended to indicate that the tic is essentially a conversion phenomenon in which, however, pre-genital impulses play the part ascribed to infantile genital impulses in the case of classical conversions. Some writers point out the resemblance of tics to *hysterical* conditions of a choreiform and spastic type (*torticollis*), although very obviously tics are more co-ordinated than choreiform movements, and, in contrast to gross spasm, always fleeting in duration. On the other hand some *epileptiform spasms* have been regarded as gross tics. The dramatic quality of the more elaborate tics has also supported the theory that they are minute mimetic hysterias.

The relation of tic to *obsessional ritual* is also close. It is sometimes regarded as a kind of obsessional action, sometimes as one of the sequelae of an early obsessional attack. If this view be accepted, tics can be correlated with coarser habits of the nose picking, head banging and rolling, and bedwetting type. They can also be regarded as having some affinity with the *personal mannerisms* of normal individuals, e.g., sniffing, throat-clearing, grimaces of various kinds or gestures of exorcism.

Nevertheless a tic can always be distinguished from an obsessional action or mannerism by the absence of gross emotional reaction to the performance or restraint of the movement. The obsessional neurotic suffers from a sense of compulsion during both phases of his action, from anxiety and guilt over the performance of his 'bad' action and from anxiety, even depression, on any attempt to restrain his 'good' action. The ticqueur is sometimes sensitive to his tic but only because it arouses his exhibitionistic defences; he rarely suffers more than a mild discomfort on attempting to suppress it. Incidentally this correlation with obsessional actions and the mannerisms of normal people raises the question of *schizophrenic elements* (cf. *schizophrenic mannerisms* and *grimaces*): and in fact some authorities believe that tics have more in common with catatonia than with hysteria. Finally it is to be observed that after the acute phase of a *traumatic neurosis* has passed, the patient is often left with a number of tics.

In view of these complicated relations it is not surprising that psycho-analytical formulations on the subject of tic include a diversity of etiological factors. In general, ticqueurs are hypersensitive types with a strong narcissistic organisation and an incapacity to endure excessive physical stimulation or danger of attack without exaggerated defence

reactions. The tic has some resemblances at this point to reflex action, but of course reflex action of a psychically 'conditioned' nature. At a later stage of development the part played by physical over-stimulation or threats is taken over by psychic over-stimulation and threats. But at early psychic levels the reaction of the ticqueur is similar to that of the sufferer from traumatic neurosis. He tends to become fixated to the trauma which, however, he continues to repeat at frequent intervals. The exaggerated defence reactions are, however, severely inhibited and are expressed, as it were, *in miniature*. Repetition includes many elements of the original traumatic situation. Interestingly enough some ticqueurs also suffer from mild hypochondria.

In this connection it is to be noted that the mode of upbringing, in particular the disciplines inflicted by parents, seem to predispose to tic formation. Parents who combine restrained affection with an oppressive demand for good behaviour produce over-restrained reactions in sensitive children whose natural response to excitation would otherwise take the form of gross muscular activity. Their aggression is overcome by the need for love, and the tic represents a compromise very similar to that observed in psychoneurotic symptom-formations. The more massive defence reactions (violent and gross muscular activity) are represented in miniature thus expressing and at the same time inhibiting the child's aggression.

The instinctual components involved are both libidinal and aggressive. Obviously muscle-erotism plays a preponderating part in the formation. Other pre-genital components are also exaggerated, in particular respiratory and anal erotism. Exhibitionistic difficulties are marked. Blinking tics are a denial of the original traumatic scene and at the same time an indication of strong erotic viewing impulses. Some observers have regarded tics as masturbatory equivalents, the genital impulse being taken over by the muscular system, the erotism of which is exaggerated. The aggressive impulses are derived from two sources viz., a sadistic erotic attitude to the mother from whom loss of love is feared and a hostile and revengeful attitude to the father from whom aggression is feared. An infantile homosexual predisposition can also be demonstrated in many cases.

Tics can be distinguished from other forms of traumatic reaction by the fact that after they have been established they act as generalised functional defences. A traumatic neurosis may be exploited by current neurotic conflicts and may lead to the formation of true psychoneuroses. It may also be activated by intercurrent anxieties, but it does not, like tic, develop as a defence against *any* form of mental stress. Any emotional stress is sufficient to increase tic formations, in particular anxiety situations either actual or merely unconsciously apprehended.

*Stammering.* Although in most cases stammering can be legitimately described as a 'mixed type' of psycho-neurosis, or, more accurately, as a form of disorder induced by a combination of ordinarily distinct psycho-neurotic mechanisms, there is some justification for considering it at this point. Like tic, stammering arises from disturbances at different psychic levels of function. It can appear as a functional reaction to mental stress either traumatic or as a result of emotional excitations, it can be induced by conflict without psycho-neurotic symptom-formation, or, more commonly, it constitutes a psycho-neurotic symptom. It can also be correlated with certain normal and psychotic manifestations.

On the functional level stammering is obviously associated with early stages of ego-organisation, that is to say, the period when the development of speech leads to the organisation of the preconscious layers of the mind. Naturally it is influenced at this stage by earlier experiences of pleasure and pain that have been discharged in vocal form e.g., babbling, lalling, crying, sobbing, screaming, etc., and therefore takes over the function of expressing primitive libidinal and aggressive impulse. A possible correlation with tic formation is suggested by the fact that speech serves the purpose of experimental action and is therefore a psychic substitute for neuro-muscular activity. Disturbance of speech is thus a psychically economical substitute on the one hand, for massive disturbance of muscular function and on the other for massive disturbance of general mental function. Some observers have been so impressed by the importance of the libidinal aspects of vocal activity that they have refused to regard stammering as a psycho-neurosis, maintaining that it is merely the effect of a defensive process of inhibition operating on an over-libidinised activity either glottal, lingual or labial.

Moreover in the case of stammering it is possible to study more clearly than in any other condition the influence of a primitive psychic factor, namely, that of symbolism. When the child arrives at the stage of correlating speech with visual images (as when he is taught to say 'baa' on being shown a toy lamb or a picture of a lamb) and when, only a little later, he is taught the alphabet by a combination of pictorial and sound associations, letters and their vocal presentations are used as symbols by which affect can be displaced from bodily activities to both speaking and reading. Single letters induce reactions appropriate to persons or their organs and so open the door to the inhibition or discharge of functional tensions in speech. The subdivision of stammers in terms of letter inhibitions is thereby given a primary etiological basis.

At the level at which unconscious conflict interferes with the function of verbal expression, it is easy to see that both libidinal and aggressive

impulses play an important part. Through the process of symbolic displacement, letters, words and numbers become sexualised in the infantile sense. Most of the infantile sexual components play a part in the development of stammers. Some observers maintain that the fixation point of a stammerer is at the anal-sadistic phase; consequently they regard stammering as a 'pre-genital conversion' similar to tic formation. But there is no doubt that muscular, respiratory, oral, urinary, exhibitionistic and infantile genital (phallic) elements are equally important factors. This provides a convenient test by which stammers can be distinguished from the classical psycho-neuroses. The fixation points are widely distributed over different stages of development, not as in the case of the pure neuroses mainly at infantile genital levels.

The aggressive aspects of stammering are also contributed from different levels. The muscular system contributes a direct sadistic component, expulsion of words representing a destructive attack. This is reinforced by the sadistic elements of respiratory and oral erotism. Moreover the magical significance unconsciously attached to words increases the aggression value of speech. Still later the sadistic elements of anal, urethral and genital impulses contribute their quota to the destructive significance of speech. On the other hand speech symbolises life and silence death. Hence there is a constant conflict over the use or disuse of speech. This reaches its maximum intensity in the case of hysterical and catatonic mutism. There is in fact a good deal of evidence that stammering is as much a manifestation of anxiety hysteria as of conversion hysteria. It represents in part a speech phobia which in later childhood and adult life is brought out on occasions of social anxiety, e.g., recitation anxiety, anxiety of public speaking, stage fright etc. Here the exhibitionistic and aggressive factors are decisive.

As might be expected from the accentuation of anal-sadistic factors, there is a strong obsessional element in stammering. It is represented by the alternating flow and inhibition of speech. As with cases of tic a degree of unconscious homosexual fixation is usually present, more particularly in the 'situation stammers'; e.g., when the inhibition occurs only in the presence of authoritative figures of the same sex, or when it develops only during situations of acrimonious discussion. An element of masturbatory guilt is also present in the more obsessional stammers: these are frequently characterized by syllabic neologisms, the unconscious play with obscene words being represented by distorted words isolated in syllabic fragments. Study of speech difficulties in normal persons and in schizophrenia uncovers similar causal factors. Syllabic or word perseveration is a feature common to both groups.

Owing to its connection with word formation the various elements in stammering can be readily interpreted. The swallowing and biting

of words represent an oral cannibalistic activity. The alternation of expulsion and retention is certainly anal, but in those persons who value the flow of speech the urinary significance is more important. Phallic phantasies are common, the interference with speech representing at the same time a denial of potency and of sexually aggressive intent and a punishment for the unconscious impulse (stammering = partial castration). During more acute phases of stammering unconscious phantasies of pregnancy are common: the patient may even develop a transient phobia of bursting.

*Convulsive States.* Apart from their theoretical and clinical importance the convulsive states are of special historical interest to both psychoanalysts and neurologists. The concept of an ascending series or hierarchy of functions distributing, discharging and otherwise regulating afferent stimuli developed naturally from the study of the central nervous system. Psychoanalysts in their turn, starting from the concept of instinctual energy and drive (*trieb*), and studying the development of the mental apparatus and of the increasingly complicated institutions and mechanisms by which it regulates psychic excitation, adopted a *similar* concept. These common usages do not of course imply a psychophysical parallelism. But they do permit on occasion a common formulation regarding clinical conditions, as when both groups of observers regard an 'epileptic' seizure as a form of violent and archaic discharge involving sensory and psychic as well as motor systems, consequent on blocking (damming up) of stimuli (excitations), which blocking is the result of structural changes in the central nervous system or of psychic inhibitions or of both. It is all the more intriguing, therefore, to note that although neurologists as a rule look askance at any attempt on the part of the psychoanalyst to apply his techniques to 'the epilepsies,' they are ready to concede not only that these conditions are highly individual but that psychic elements play a decisive part at various phases of the convulsive cycle.

From the psycho-analytical point of view it is of interest that although the possibility of classifying psychoses and psycho-neuroses in terms of their developmental reference was speedily visualised, the superposition of these states on earlier and more primitive forms of psychic function was not so readily recognised. At any rate psycho-analytical formulations on this subject were and still are rather scanty. The outstanding exception was provided by psycho-analytical work on the epilepsies in which the operation of archaic levels of psychic function was established. This came about not long after Freud had effected his distinctions between anxiety-neuroses, the neurasthenias and the psycho-neuroses. In these latter conditions, however, the influence of early psychic levels of function has not been so fully appreciated.

Needless to say the division of convulsive states into 'epilepsy' and

'the epilepsies' does not exclude a wider approach to the subject, as may be gathered from a list of psycho-pathological conditions in which convulsive manifestations are observed. Thus they are to be found in the conversion hysterias, in anxiety seizures (although in the dream state and in hysterical narcolepsies the manifestations are usually regarded as epileptic 'equivalents'): they have been (doubtfully) recorded in acute obsessional states: some gross tics have been regarded as miniature epilepsies: epileptic syndromes are observed in the traumatic neuroses: some convulsive seizures are classified as a variety of organ-neurosis: they are recorded (again doubtfully) in anxiety-neurosis: they are associated with hypochondriacal symptoms: and they appear in the catatonic forms of schizophrenia.

As with other psycho-somatic states, correlations have been made between convulsive seizures and manifestations occurring in 'normal' individuals. Two forms in particular are significant, first, various muscular mannerisms, twitchings, teeth grindings, jaw and hand clenchings and, second, muscular manifestations of emotional tension, in particular rage affects where a variety of spasms can be noted. Convulsive seizures can act at the same time as affect equivalents and as defences against anxiety, the spasm being a tonic substitute for action which however gives no obvious clue to the anxiety stimulus.

In short the manifestations of convulsive symptoms are sufficiently widespread to call for a 'serial' classification, which can also be applied with advantage to the true 'epileptic' group. Thus, following the principle of proceeding in depth from higher and more easily analysed levels, we can again isolate (1) high psychoneurotic levels, (2) psychotic levels, (3) functional levels at which 'conflict' plays a determining part, and (4) archaic functional levels at which excessive stimulation of a constitutionally predisposed individual, or normal stimulation of a personality already suffering from chronic mental stress short-circuits all higher function and gives rise to a convulsive discharge. Since the amount of 'conflict' present in traumatic and affect convulsions varies a good deal, these can be traced to any of the four levels but they commonly arise from disturbances of the two deepest. Incidentally muscular 'organ-neuroses' associated with epilepsy do not present the typical 'standardised' reaction seen in other organ neuroses, but it is well to consider them as belonging to the third group. Naturally their most prominent symptom is one of *inhibitive* disorder of the voluntary muscular system, since it is this inhibitive defence (blocking of movement) against over-excitation that beyond a certain point releases violent discharges by involuntary movement.

A similar classification in depth had been adopted by many neuropsychiatrists in describing the epilepsies. Having enumerated the organic factors responsible for various special types they are ready in



the case of genuine epilepsy not only to postulate instinctual defects causing maladjustment at deep levels but to recognise as contributing factors defect at higher psychic levels. Somewhere between these they are accustomed to isolate a group of 'affect epilepsies', commencing commonly in childhood and conditioned by psychological reactions to 'intolerable stress'. Under a broader system of classification these would be placed in either of the two deepest functional levels, the archaic and the organised.

The importance of deeper levels of function in convulsive states is confirmed by the clinical data assembled by neurological, psychiatric and psycho-analytical observers. Originally the peculiar character reactions observed in epileptic types were considered to be degeneration products; but it soon became necessary to distinguish a predisposing epileptic constitution or character from true degenerative sequelae. The constitutional type is variously described as morose; irritable; hypersensitive; suspicious; egocentric and infantile; ill-humoured and aggressive despite a certain shallow sentimentality; lazy, undependable and given to fabrication; suffering readily from exhaustion and muscular fatigue; frequently depressed and hypochondriacal especially before an attack. These descriptive aspects are subsumed by the psycho-analyst in the general formulations that the epileptic type is intensely narcissistic; that his ego presents many archaic features sometimes paranoidal in type; that his libidinal attachments to objects are weak; that he is sexually undeveloped or retarded with, appropriately enough, many elements of infantile fixation derived from component sexual impulses; that he is autoerotic in habit, frequently exhibitionistic and often homosexual in disposition; and finally that his unconscious aggression and sadism are of an intense and explosive nature. Both sets of observations suggest what might indeed be inferred from the series of etiological levels previously described, that the factor of *sudden regression* is one of the decisive elements in the seizure.

Corroborative evidence is forthcoming from a number of sources. The incoordinate movements, infantile attitudes and gestures, and psychic infantilism exhibited when the patient emerges from a fit, together with the symptoms of psychic degeneration observed in long standing cases suggest a deep level of instinctual disturbance, an impression which has been strengthened by psycho-analytical studies of different elements in the seizure. Not only are many of the precipitating situations psychically determined particularly by the unconscious need to escape from psychic stress, but associative examination of the *aura* has disclosed, in addition to sensory explosions of a discharging type, many elements having a symbolic significance. This is more obvious in the case of stereotyped hallucination. In a number of cases a correlation between these symbolic expressions and early situations of intense

anxiety has been established. In this sense the seizure can be regarded as in part an archaic anxiety equivalent arising in persons of somatic predisposition canalised through the central instead of the autonomic nervous system, and discharging itself in physiological symptoms.

Studying those convulsive seizures in which the action of psycho-neurotic mechanisms of conversion can be clearly established, it is possible to indicate some of the more complex psychic factors determining the attack and the instinctual fixations from which they spring. The post-epileptic gastro-intestinal disturbances observed, although not exclusively, in these varieties indicates a strong oral-sadistic factor, as do tongue biting and jaw grinding. A factor of displacement from anal-sadistic (sphincter) levels to the general musculature has also been suggested. The relation of both minor and major attacks to infantile genital interest is not hard to surmise. Muscular spasm as a displacement of erection and as an expression of orgasmic contraction is frequently noted. Indeed the phenomenon of orgasm is frequently referred to as a 'little epilepsy'. And since the aggressive component in genital sadism is found to be accentuated in such cases, the convulsion can sometimes be regarded as a condensed expression of genital aggression or sadism. It is to be noted, however, that the convulsive seizure, though dramatic enough in the descriptive sense, tends by its explosive violence to conceal the element of 'unconscious dramatisation' which is so marked a feature of some conversions and hysterical seizures. Incidentally it is sometimes held that early observation of or phantasies of parental coitus (primal scenes) is a contributing factor. This accentuation of unconscious genital elements is responsible for the view that faulty (excessive, rather than deficient) repression plays an important part in the seizure by increasing intrapsychic pressure: when the repressed excitations regress to more archaic levels they give rise to an explosive discharge.

Below the more advanced psycho-neurotic levels, some mechanisms of a psychotic type play a part in convulsive seizure. This view has been confirmed by psycho-analytic investigations and is in any case corroborated by clinical observation of alcoholic, paranoidal and schizoid characteristics present in some cases of epilepsy. In fact if psycho-somatic states were subdivided in depth and compared with true symptom-formations, it would be found that many epilepsies had the same 'value' as psychotic symptoms in particular acute depressive states.

Finally it is to be observed that as a rule differential diagnosis calls for a prolonged period of close observation. The most reliable distinction between hystero- and other forms of epilepsy lies in the fact that, as was pointed out in the introduction to this chapter, whereas psycho-neurotic symptoms have psychic content which is frequently

dramatised by but of course distorted in the symptoms, purely functional disturbances although serving an economic purpose have no such content. The clinical history and a general psycho-analytical examination may be sufficient to effect a distinction along these lines; but in many cases it is necessary to undertake a short probationary analysis before a reliable diagnosis can be effected.

*Some Therapeutic Considerations.* The foregoing survey of psycho-somatic and allied conditions has been governed by two main objectives, first, to distinguish functional conditions and psycho-somatic states from true 'symptom-formations' (Freud) and, second, to indicate that each phase of mental development can give rise to characteristic dysfunctions. This 'developmental series' of disorders reaches its highest point in psycho-neurotic formations, in particular the obsessional neuroses. Naturally the actual symptom picture with which the observer is confronted does not at first allow of a precise separation of different 'layers'. In some instances, for example, an anxiety neurosis is a kind of psycho-neurotic aura, in others it is a prodromal symptom, in still other, rarer, instances it can be isolated in a 'pure' state. And the same can be said of the neurasthenias, the traumatic neuroses and the organ-neuroses. In any case disturbance of the various levels can occur simultaneously, thereby producing a composite symptom picture.

This serial conception of mental disorder is not only of theoretical and diagnostic value but has an important bearing on the psychotherapy of psycho-somatic and allied disorders. Hence, although the therapeutic aspects of psycho-analysis are considered in a special section (section III) it is appropriate to introduce here some general reflections on the treatment of psycho-somatic conditions. This is all the more necessary since in recent years the field of psycho-somatic medicine has become a happy hunting ground for all sorts of specialists whose training and qualifications vary widely. Two preconceptions have added strength to this movement. Many of those who hold that the psycho-therapy of psycho-somatic states should be the concern of specialists, are nevertheless under the impression that the treatment called for is in some way simpler than that required in the case of the neuroses. Others hold that since psycho-somatic complications of organic disease are commonly met with in general practice they should be dealt with by the general physician. It is desirable therefore to indicate the respective roles of the practitioner and of the psycho-somatic specialist.

In the first place it is clear from the foregoing survey that diagnostic and prognostic skill in this field calls for more rather than less extensive training than is necessary for psycho-analytical diagnosis and prognosis of the psycho-neuroses. It is necessary not only to be familiar with the different levels of psycho-somatic and psychic disorder but to

recognise their characteristic mechanisms, their dynamic sources, their unconscious content (if any) and the therapeutic forces that can be mobilised in each particular type. Only with this equipment is it possible to apply appropriate measures of treatment.

In principle therapeutic measures can be subdivided, first, in accordance with the techniques applied and, second according to the part or function or activity of the mind at which it is directed. From the point of view of technique there are only two main forms of psycho-therapy, namely, psycho-analysis and suggestion. There are of course a number of elaborate techniques of an apparently 'analytical' nature but to the extent that these do not analyse the transference that develops between the therapist and his patient they do not eliminate the factor of suggestion. The point of application in psycho-analysis and in suggestion also differs: suggestion is directed mainly towards the symptoms of which the patient complains; psycho-analysis mainly towards the unconscious mechanisms, mental structures and instincts, disorder of which gives rise to the symptoms. Perhaps more significant in the present connection is the fact that whereas psycho-analysis can be freely applied at *any* point of the psychopathological process, from the precipitating factor to the final symptom-formation, and can explore widely the psychological antecedents giving rise to the neurotic predisposition, the role of suggestion proper is limited to providing an emotional counter either to the symptom or to its obvious precipitating factor, or, in its hypnotic form, to exploring for purposes of elaboration or catharsis the immediate antecedents of the symptom. In other words it is open to psycho-analysis to investigate all but the 'preverbal' levels of the mind, whereas the range of suggestion is limited by the 'accessibility' of the patient's mind, which in turn depends on the balance existing between the patient's rapport with (spontaneous transferences to) the physician and his functional or emotional need for illness.

Bearing in mind therefore the various mental levels and etiological factors associated with the disorders described in this section it is possible to indicate with some accuracy the scope of the different psychotherapeutic methods employed to relieve them. In the first place, commonsense considerations would suggest that since disturbances of excitation and discharge are responsible for many psycho-somatic manifestations, a first step in treatment should be the elimination of any further stress. As has been pointed out, in cases of uncomplicated anxiety neurosis in which elements of sexual overstimulation and inadequate discharge are present, rapid improvement can be brought about by inducing the patient to follow a more natural sexual hygiene. The rationale of treatment of battle strain is based in part on similar considerations. Further, when the treatment of organic disease is hampered by current emotional conflicts of an obvious nature it

requires no great perspicacity to realise that elimination of such strains will have a beneficial effect. No doubt the illusion that psycho-somatic treatment is a comparatively simple matter is fostered by happy experiences of applying commonsense remedies to precipitating factors. Even sending a psycho-neurotic to Brighton may prove to be a remedial measure justified by occasional alleviations. But unless the physician is familiar with the transient alterations in emotional transferences brought about by a 'change' he is more or less working in the dark, and is laying up for himself a good deal of avoidable disappointment.

On the other hand traumatic neuroses call for more than mere reduction or elimination of the precipitating factor. The element of trauma has already set up a number of reactions which, even though they be spontaneous attempts at cure (e.g., the repetitive battle dream), are nevertheless in the clinical sense symptoms of disorder. And he would be a sanguine psychotherapist who hoped to cure an established neurasthenia, hypochondria or organ neurosis merely by ventilating obvious precipitating factors. Two further measures are necessary, first, the free promotion of discharge of excitation and, second, the re-adjustment of damaged ego-function. The first of these aims can be secured by various forms of catharsis with or without suggestion, hypnosis or narcotic adjuvants, by psycho-analysis alone or by a combination of methods. The second calls for an accurate knowledge of unconscious function. It is true that many forms of rehabilitation are practised by physicians who have little or no understanding of unconscious function; nevertheless rehabilitation is as much a rule-of-thumb method as the ventilation of obvious precipitating factors.

When we come to consider the treatment of cases in which 'functional defences' are complicated by 'conflict defences' or which are due almost exclusively to conflict defences, it is clear that rule-of-thumb methods are not desirable. The therapist must be trained in the techniques either of suggestion or of psycho-analysis. Similarly in the case of psycho-somatic disorders complicated by true psycho-neurosis: to deal with this complication either some variety of suggestion is employed or the case must be submitted to psycho-analysis. It should be noted, however, that there is a cardinal difference between the psycho-analysis of a psycho-neurotic symptom and the application of psycho-analytical methods in the treatment of functional or psycho-somatic conditions. In the former instance the spontaneous transferences existing at the commencement of treatment develop into a special neurotic repetition of infantile situations. This is called the *transference neurosis* and it is through the analysis and resolution of this 'neurosis' that psycho-analysis achieves its more permanent results (see Section III). In psycho-somatic states only a mild variety of transference

neurosis appears: the analyst has to operate mainly with spontaneous transferences and is in that respect not much better off than the suggestionist. As has been seen psychosomatic types have a narcissistic constitution and character which act as a further obstacle to transference development. A propos of suggestion, the fact that some apparently superficial methods may bring about alleviation is due not to the procedures employed but to the degree of transference activated by their use.

The role of the general practitioner is therefore clear. He can strive to reduce precipitating factors of an obvious kind, he can make the patient aware of the part played in his disorder by current emotional strains, he can employ various devices to promote discharge of obvious pathogenic stress, he can advise the patient as to changes of familial, recreational, social and occupational conditions, he can exploit his spontaneous capacity to induce a state of transference in his patient and, should he happen to be practised in the art of suggestion, he can employ direct suggestion. Beyond that he cannot go either with reasonable chance of success or indeed with safety.

As far as the 'psycho-somatic specialist' is concerned, only two comments need be made. In the first place the title is a misleading one. It is unnecessary and misleading to call a specialist in kidney disease a 'glomerular expert.' Mental specialists are more usefully classified according to their theories of total mental function and psycho-therapists according to the technique they employ. Secondly the psycho-somatic specialist who believes that treatment of psycho-somatic disorders is simpler than any other form psycho-therapy is an optimist, if not indeed a menace.

*Chapter XII*

## PSYCHOSES

Psycho-analytical interest in the psychoses has undergone many vicissitudes. For a considerable period it was mainly theoretical. Psycho-analytical observations of psychotic states were drawn on to amplify theories of mental function that had already been elaborated as the result of direct psycho-analysis of the psycho-neuroses. At this period it was generally held that psychotic patients were too 'inaccessible' to allow of direct psycho-analytical treatment. In fact the psycho-analyst's preoccupation with treatment of the neuroses encouraged him to neglect direct observation and analytical study of the psychoses on which a sound perspective of mental development and function depends.

At the present time the pendulum is beginning to swing in the opposite direction. An increasing number of psycho-analysts take the precaution of undergoing a clinical training in psychiatry. Partly for this reason, and partly because, from the developmental point of view, study of the psychoses throws a considerable light on the more primitive phases of mental function, psycho-analytic theories now tend to be overweighted with hypotheses based on observation of the psychoses. This state of affairs is not without its dangers. More than a little caution is necessary when dealing with data which in many cases cannot be subjected to the test of direct psycho-analysis. In short although to be a good psycho-analyst it is necessary to understand psychotic function, an exaggerated concern with psychotic function leads to poor theorising and indifferent practice.

From the clinical point of view psycho-analysts are in general agreement with psychiatrists in isolating three main group reactions: schizophrenic, paranoid and (manic) depressive. Their therapeutic interest in these groups is however limited for the most part (a) to so-called 'borderline' cases in which either larval psychotic reactions are observed, or psychotic formations are screened by psycho-neurotic symptoms or neurotic character formations; (b) to mild types of manifest psychosis mostly of the depressive group, less frequently schizophrenic and still more rarely paranoid in nature; (c) to psychotic types of character formation. Whether many advanced cases without gross deterioration will respond to psycho-analysis is still an open question. Pessimistic views on this point are to a certain extent influenced by the difficulty of applying the ordinary (classical) 'ambulant' technique of psycho-analysis. This however shews a lack of enterprise

on the part of the analyst who in any case tends to be unduly timid in face of therapeutic caveats uttered by the institutional psychiatrist. It is true that psychotic cases require not only special methods of psycho-analytical approach but special environmental settings, e.g., various degrees of supervision. On the other hand it can be maintained with some justification that no form of 'handling' of the psychoses which is not based on psycho-analytical understanding can be regarded as more than a 'hit or miss' method. Certainly a knowledge of psycho-analysis is essential to intelligent observation of psychotic states.

Another unsettled problem is whether psychotic types treated by convulsive, surgical and other empirical techniques are more readily accessible to psycho-analysis during the remissions that so frequently follow these procedures. But on the whole the psycho-analyst's interest lies in the early recognition and prevention of psychotic breakdown. His efforts in this direction are most successful when applied during childhood and adolescence, periods at which the prodromal symptoms of the psychoses differ considerably from those observed in the established psychoses. Hence *nicety* of diagnosis is at first of less consequence than *early recognition of a positive psychotic trend*. Once a provisional diagnosis has been effected the next step is to decide whether to embark on a period of psycho-analytical observation and/or treatment, or to recommend non-analytical forms of disposal.

Although psycho-analysts have for the time being adopted the broader classifications of the psychoses suggested by their psychiatric colleagues, this is largely for convenience in presentation. Sooner or later these groupings will be replaced by clinical divisions based on a developmental approach to mental function. This will involve appropriate changes in clinical terminology. A step in this direction was made by Freud when he suggested that depressive states could be more appropriately called 'narcissistic neuroses'. And certainly it would be hard to find more inappropriate if not positively misleading terms than 'schizophrenia' and 'paranoia'. 'Dementia praecox' had at least the virtue of singling out a clinical feature of the condition, as has of course the term 'melancholia'. In the meantime the psycho-analyst can best indicate the developmental aspects of the psychoses by describing in the first instance psycho-analytical formulations concerning depressive disorder.

## 1. MANIC DEPRESSION: MANIA AND MELANCHOLIA

When assessing the significance or level of any psychic state, either normal or disordered, four main points should be kept in mind, (a) the nature and intensity of the associated affect (b) the type of ego-organisation present (c) the predominant type or level of instinctual develop-



ment and (d) the relation of the individual to his object-world (reality). Information regarding the instinctual level can be obtained both directly and from observations made when studying ego-structure. Since affect is the more powerful of the two psychic derivatives of instinct, the other being ideational presentations, the affective state of the patient is the most important of these four criteria. In the study of dreams, for example, the importance of both manifest and latent content can be assessed by reference to the affective tone of the dream or to the defences against affect manifested in the dream. Naturally when studying affects both in dreams and in psychopathological states it is necessary to distinguish between secondary or fused affects and primary affects. Primary affects are the most reliable of all psychic 'indicators'.

*Clinical Aspects.* As the terms 'depression', 'melancholia', 'cyclothymia' and 'manic-depression' suggest, the depressive states might be described as *affect psychoses*. Hence it is desirable in the first instance to present a clinical outline of the condition in terms of the affective changes, or divergences from normal affect, observed. On the other hand to lay exclusive emphasis on the affective aspects of a depressive state would be to give a totally misleading impression of it. For not only does this disorder lead to periodic disruption of the faculty of reality proving (delusions, hallucinations and abandonment of realistic instinctual responses to the object world) but these psychotic reactions are associated with grave disorder of both ego and super-ego and with grave abnormalities in instinctual development. It cannot be over-emphasised therefore that a *depressive psychosis is at the same time a form of narcissistic disorder of the ego, a malignant hypertrophy of the super-ego and a sign of disorder of the sexual and aggressive impulses*. It would not be far short of the mark to say that depression is an 'affect-psychosis', a 'narcissistic psychosis', a 'guilt-psychosis' (in contrast to a 'guilt-' or 'obsessional neurosis') and, though this last term is not entirely satisfactory, an 'oral-sadistic psychosis'.

Beginning therefore with the affective aspects and omitting the more elaborate details and clinical differentiations (which can be obtained from psychiatric text-books), the following features may be singled out. Manic-depressive patients exhibit recurrent *cycles* of mood. In typical instances they pass from a phase of depression and inactivity to a phase of mental exaltation with hyperactivity. This is usually followed, sometimes preceded, by a period during which they seem more normal and which is usually described as an 'intermission'. In many cases this apparently normal phase is characterised by obsessional mechanisms and indeed it is not hard to detect obsessional characteristics

in the personality of depressives. This suggests that during 'normal' and 'intermittent phases' the patient is able to deal with his unconscious difficulties by means of obsessional mechanisms but that during depressive or maniacal phases he has recourse to deeper defences and exhibits consequently more archaic forms of discharge.

The phases vary in relative proportion, sequence, duration and intensity from patient to patient; and of course a great variety of permutations and combinations of the different phases and characteristics can be observed. The type of cycle, however, usually remains fairly constant in any given case. In mania depressed reactions *appear to be* absent, though traces can frequently be detected on careful examination; and the substructure is in any event depressive. A maniacal condition can appear as a sporadic attack, the prognosis of the attack itself being often favourable. Intervals between recurrent attacks of mania vary considerably and the condition may become chronic. In melancholia the exalted phase is missing except in so far as it is represented by states of severe and deep seated chronic depression.

Changes of mood are, of course, common among people who shew no sign of mental illness and for this reason the sequence of phases in mild manic-depression (cyclothymia) is sometimes regarded as an exaggeration of normal alternations of feeling. Moreover, it is common knowledge that when normal people are subjected to prolonged states of frustration, humiliation or disappointment they tend to react with a decrease of interest which may proceed to deep apathy: also that they celebrate any relief of tension by a display of gaiety, sometimes, as in the case of intoxication, artificially induced. The artistic temperament with its bouts of intense creative activity and slump periods of barren inertia is typically manic-depressive. Perhaps the most significant normal manifestations are those reactions to the loss of loved objects which are described as *grief* and *mourning*. Here the psychic apparatus is concerned simultaneously with the discharge of psychic pain and with the gradual detachment of cathexis from psychic representations of the object, a task which calls for the repetition of (decreasingly) painful psychic reactions. The general reduction in psychic interest caused by absorption in this task is reflected both in mood and in psychic activity, although occasionally the process of mourning is interrupted by fleeting attempts to transfer cathexis to new objects, a mechanism which, as will be seen, is characteristic of a state of mania. Anthropological parallels drawn from the rituals of primitive tribes go far to suggest that at deeper levels the phenomenon of normal mourning has much in common with the pathological varieties present in melancholia. Depression is incidentally a common accompaniment of neurotic states in which an original ambivalent reaction to objects can be established.

Turning to the ego aspects of depression, it is not difficult to observe that depressive cases suffer from an exaggerated and *pathological* form of *narcissism*. This statement frequently gives rise to misunderstanding. Narcissism is a perfectly normal stage of development and a healthy narcissism is a prerequisite of healthy mental function. But where narcissistic fixation has occurred or where narcissistic defences have been established, the ego is not only essentially weak but gets little support from object relations which are usually of a tenuous variety. What is loosely called 'excessive' narcissism is paradoxically a sign of 'weak' narcissism which has set up 'strong' narcissistic 'defences'. It is frequently held for example, that feelings of omnipotence are a sign of strong positive infantile narcissism but this is seldom the case: omnipotence is mainly a defensive reaction to weakness.

These findings are borne out in the case of depressive narcissism by certain clinical considerations. Interest in the body-(narcissistic)-ego is greatly increased. Hypochondriacal ideas are common, e.g., convictions that some internal organ is misplaced or suffers from some malignant and poisonous disease. This can proceed to the delusional idea that some animal or devil exists inside it. The apparent apathy is really a sign of the most intense narcissistic (defensive) concentration, a state which also accounts in part for symptoms of psycho-motor retardation. Inability to eat, as will be seen, is connected with poisoning ideas and with phantasies of sadistic oral aggression; and the reduction of activity is a sign that the body is held to be the seat of the most violent and dangerous activities. In this sense the reaction is similar to the muscular and ideational inhibitions observed in traumatic neuroses.

The most convincing proof of the narcissistic nature of depression is to be found by study of the *maniacal ego* which to superficial examination appears to present a complete antithesis to the depressive ego. The patient feels 'good' (euphoric), full of energy and intensely, even feverishly, active. The euphoria may indeed go on to a state of megalomania and the activity becomes literally frenzied. Whereas the depressive suffers from profound loss of self-esteem, the maniac has apparently acquired an immense increase of self-esteem. His vitality is apparently super-abundant in contrast to the barren devitalised and 'empty' condition of the depressive. In both cases, however, the manifestations are abnormal. The hugely exaggerated self-love of the maniac is as much a sign of weakness (including absence of healthy narcissism) as the apparent absence of self-love of the depressive. This is borne out by the 'flight of ideas', 'flight of actions' and 'flight of object relations' (or 'object-hunger') manifested in maniacal cases. The mental activities concerned are literally 'fleeting' and exhibit the poorest of capacity for true object relations, always a sign of weak ego development. Both

types shew the character reactions of domination and emotional oppression, unmistakable indications of an insecure and voracious ego. Some depressives, as well as entertaining delusional ideas of being 'unlovable' (unworthy), openly accuse their families of 'not loving' them.

That the *super-ego* of the manic depressive is in a state of the most profound disorder is clear from the manifestations appearing during both depressive and manic phases. It is indeed of considerable historical interest that Freud's discovery of the *super-ego* was the result of his study of depression. In depression, misery is accompanied by self-hatred which may culminate in suicide. In relatively mild cases the self-hatred may be confined to feelings of worthlessness: in melancholia delusional self-accusations take grotesque forms which nevertheless are significantly concerned with 'sins' of a sexual or aggressive nature. In mild cases of mania on the other hand the patient experiences a sense of freedom and release, as if a grievous burden had been lifted from him, or he were rid of a heavy obligation. He now feels that instead of being unloved, as in the depressive phase, he is loved by everybody: nevertheless he is quick to react with irritability or rage to any apparent disparagement or interference. In other words the pathological 'mourning' of the depressive becomes the 'festival' of the maniacal phase. All this falls into perspective when it is realised that the gross and savage caricature of conscience exhibited by the depressive is overthrown by the maniac who then produces a caricature of the sanguine and facile ego of a child, whose mind has not yet been subjected to *super-ego* organisation and domination. In other words the ego presented by the depressive is really a totalitarian *super-ego*: the *super-ego* of the maniac for the time being has disappeared.

Disorder of the *instincts* is equally easy to recognise. The inaccessible and withdrawn state of the depressive which may proceed to stupor is really a sign of abandoned object cathexis; but the 'object-hunger' of the maniac with his rapid increase of casual genital interest is more than a mere return of interest in objects; it shews only too clearly the weakness of his original object relations. He has no reality valuation of his fleeting objects whose existence merely ministers to his need for omnipotence over them.

The importance of narcissistic and instinctual factors in depression can be confirmed by study of cases in which a precipitating factor can be established. Generally speaking, failure in work or love of a traumatic type is liable to provoke a depression, e.g., lack of success in business, loss of money or reputation, situations giving rise to remorse, disappointment in love relations, or loss of love objects (either animate or inanimate) the death of persons to whom the potential depressive has been emotionally attached. The primary traumatic reaction then

gives rise to a narcissistic regression and injury. In many instances no very obvious precipitating factor can be detected and the case appears to be more endogenous than reactive in type. Closer study indicates nevertheless that true precipitating factors do exist which have taken effect through their symbolic value, that is to say, the unconscious mind has detected a situation threatening loss and has interpreted it in terms of traumatic loss or injury: the patient may then produce delusional ideas of loss of money or of poverty. A similar unconscious identity of food, money and love is observed in cases of juvenile delinquency, in drug addictions and in a more negative (hostile) sense in paranoia.

The existence of constitutional and of organic predisposing factors is generally assumed but no precise observations have been made on this aspect of manic-depression. Certain psychic predispositions and functional tendencies are, however, easy to establish, in particular an incapacity to stand traumatic stress. The depressive not only reacts badly to states of frustration but seems incapable of enduring the slightest *delay* of instinctual gratification. He also exhibits a hypersensitiveness to psychic pain and is in consequence very easily 'hurt'. A history of early physical illness affecting nutritive functions is often obtained. In general there is a good ground for assuming a constitutional excess of primary masochism.

*Etiology.* Although at first sight the etiological aspects of the psychoses seem more obscure than those of the psycho-neuroses and although at present less is actually known of the origin of the psychoses it is a mistake to assume that the latter are more difficult to understand or that they have a more complicated etiology. On the contrary the deeper one penetrates the developmental layers of the mind, the simpler the explanation of any disorders that may be associated with them. An obsessional neurosis is much more complicated and much more difficult to understand than a schizophrenic episode. The latent content of a dream is much more intelligible than its manifest content. Indeed a normal person is much more mystifying than a madman.

Amongst the various reasons for this misapprehension three are of special significance. The more or less normal observer whose own psychotic tendencies are comparatively well in hand defends himself against a too ready appreciation of psychotic ideology by letting himself be puzzled by it. Secondly, the average analyst who is interested in the more complicated manifestations of conflict observed in the psycho-neuroses rather naively expects to find similar complications at more primitive levels and usually ends by postulating adult secondary processes in the mental function of sucklings. Hence some of the more absurd hypotheses and reconstructions of early infantile development

that have recently gained currency. These are essentially subjective theories projected into child psychology. Many of these errors can be corrected by a study of the functional types of psycho-somatic disorder and of psychopathic reaction. The real problem of psychotic symptom formation is to ascertain in each case the level of narcissistic regression at which conflict loosens functional forms of inhibition or discharge. And thirdly, the psychoses are often regarded by analysts as more complicated than the neuroses because they do not respond so well to analysis. But as will be seen this is due not to their complexity but simply to absence of effective therapeutic transference.

Having familiarised himself with the mechanisms of 'symptom-formation' (Freud) present in the psycho-neuroses, with 'conflict' elements present in organ-neuroses and with the more primitive 'functional reactions' present in states of psychic over-excitation, for example, in the simpler traumatic neuroses, the student is in a favorable position to investigate the psychoses. His first aim should be to determine what elements of true symptom-formation are present. This involves the usual assessments of constitutional factors, somatic or psychic predispositions, precipitating factors, introversions of instinct, regressions and compromise formations. And his second should be to investigate in detail the fixations and traumatic experiences (endopsychic and environmental) which contribute to psychotic disposition. Finally, having distinguished the instinctual stresses responsible for psychotic reactions, he can study the unconscious mechanisms and ego or super-ego reactions characteristic of any given psychosis.

Little more need be said about the constitutional and predisposing factors in depressive psychosis. As has been noted the precipitating factors vary widely between real and imaginary loss or trauma. The first important difference between neurotic and depressive states lies in the stage of introversion. In the psycho-neuroses libido is *withdrawn* from objects and gives rise to an increase in phantasy activity which heralds a psychic regression: throughout the regression, however, the organisation of the ego remains practically unaltered. In the depressive states object relations are *abandoned* and the full force of the withdrawn object libido initiates a regression to infantile stages in which however the ego and consequently the super-ego participates. As in the neuroses the depth of regression is determined by unconscious fixation points: the libido regresses to infantile positions and the ego to a stage between narcissism and early super-ego formation. The consequences of these two manifestations of regression must be considered separately.

A number of considerations point to the fact that oral libido and oral sadism are heavily reinforced in depressive cases. In general the manic

depressive sequence corresponds to the alternation of reactions of infants who have been traumatically frustrated at an oral level and subsequently gratified. In cases of melancholia a deeper oral trauma is manifested, and repetitively dramatised in the 'pseudo-annihilation' of depressive psycho-motor retardation (stupor). The existence of cannibalistic phantasies and phantasies of being poisoned, the refusal of food and marked gastric hypochondriasis all point in the same direction. It should be clearly understood, however, that in the average case of depression the oral fixation is only relative. Other infantile components of sexuality are also involved. Skin erotism is constitutionally reinforced and there is abundant evidence of a heightened masochism which increases in direct ratio to the amount of frustration experienced at the various stages of object-relationship. In many cases delusional and hallucinatory products together with abdominal and excretory hypochondriasis and innumerable forms of regressive behaviour e.g., soiling etc., point to the importance of anal and urethral erotism of a markedly sado-masochistic type. Although depression is commoner in women, it is not hard to shew that in both sexes unconscious homosexual libido is reinforced. Infantile genital positions are reached by the potential depressive, but the attachments are weakly held and easily abandoned on the threat of frustration. In all cases the importance of aggressive impulses is unmistakable: each libidinal component is associated with strong sadistic reactions.

*Despite these plain indications of early libidinal fixation of a frustration type it must not be assumed that the ego organisation activated in the regression is of the same developmental level. This can best be understood by examining the nature of the narcissistic regression. In normal development, narcissistic (or primary) identification of the ego with (what the observer knows to be) its objects precedes true object formation; and for a time object relations are built up on a narcissistic basis. Hence object relations are capable under stress of regressing to identification. This is what happens in the depressive case. It is along the path of identification with objects that a pathological process of introjection of abandoned objects is initiated. A pathological increase of narcissism ensues.*

On the other hand the total ego regression does not, except in severe cases, reach what might be called schizophrenic levels. The whole clinical picture of manic-depression suggests that the withdrawn energies are not totally involved in a regression to primitive narcissistic levels but that a large amount in particular of aggressive energy is divided between the ego and the super-ego, and is absorbed by maintaining an acute conflict between these two institutions. This observation, which can be readily confirmed analytically, indicates that the level of ego fixation is one at which the super-ego has (no doubt in many

cases precociously) reached a stage of organisation at which it can effectively control the discharge of ego-energies, a point which normally is not reached until the anal stage is well established (about the age of two-and-a-half years). It is also confirmed by the fact that a large number of depressives have reached not only a high state of ego organisation but a system of genital object relationship which only breaks down under traumatic stress. Moreover in these cases it can often be demonstrated that some of the early traumatic experiences leading to depressive predisposition occur at an early genital level, e.g., the birth of rival children, genito-sexual humiliations, observation of primal scenes, castration anxiety and/or penis envy of a traumatic type.

But if, on the one hand, instinctual disturbances in depression can be traced to an early level and, on the other, the characteristic ego disturbances are due in part at any rate to disturbance at much later super-ego levels, how are we to account for the archaic features of the condition, including the apparently baffling paradox of the suicidal attempt? To answer this question we must reconsider the consequence of the narcissistic regression, this time from the point of view of traumatic overstimulation and excitation. Briefly the regressive hypercathexis of narcissistic levels can lead either to further ego-regression (melancholic stupor) or it can set in action the mechanisms that originally facilitated an advance from narcissism to object choice. Historically the first set of differentiations in primary narcissism are due to the development of the primitive body-ego (more accurately to the development of the body-ego nuclei that record the vicissitudes of corporeal pleasure and pain experience): the second set of differentiations are due to the development of true ego-object nuclei: and the third set to the introjection of abandoned objects which sets up primitive super-ego nuclei. *The glaring abnormality of super-ego function in depression is therefore in part a primitive functional attempt to discharge traumatic over-excitation using for the purpose one special mechanism – the mechanism of introjection.* It is an attempt at spontaneous cure through introjection. This part of the symptom picture corresponds to a *traumatic psychosis*. It has in fact relatively little psychic content. On the other hand it cannot be questioned that depressive symptoms like psycho-neurotic formations are also closely packed with psychic content. This is derived mainly from early levels but includes important contributions from later levels up to and including the infantile genital level. Although therefore in describing the influence of introjection in depression it is convenient to speak of it in terms of psychic content, it is the traumatic aspect of introjection that gives rise to the most archaic manifestations of depression.

The link between these two levels, the psycho-somatic (functional psychotic) and the 'symptom-formation' level is easy to indicate. It



is an unconscious symbolic link between oral experience and early forms of love and hate experience of objects. Symbolism is the earliest form of pre-conceptual thinking based mostly on mistaken identities of corporeal experience and primitive correlations of those experiences with the objects of component instincts, laid down in primitive corporeal ego-nuclei. To put the matter rather too simply: food is a sign of love, its absence is a sign of hate. Later by a reflexion of sadistic impulse its presence can be a sign of hate (poisoning). Eating and swallowing constitute the earliest form of intercourse with objects, vomiting the earliest repudiation. These early symbolic valuations cannot, however, become part of a purely psychic system until purely psychic introjection of objects takes place and this happens at a much later stage. It is a common blunder to identify swallowing or incorporation with introjection and to speak of a physical experience or process as if it were the *same* as a psychic activity. *In the case of archaic depression we can observe a reactivation of the phase that lies between the formation of corporeal ego-nuclei and psychic introjection of objects.*

One effect of this reactivation might be called loosely *a summation of corporeal and psychic traumata*. In normal and also in psychoneurotic cases early functional methods of discharge are sufficient to deal with early corporeal frustrations without fixed symptom formations, provided of course the balance of gratification is on the right side. But where, as in the depressive case, constitutional sensitiveness to trauma is excessive or where the balance of pleasure-pain is on the wrong (physically painful) side, the infant has not been able to discharge his states of frustration tension; there is no gap or barrier between earlier corporeal frustrations and later psychic frustrations in object relationships. Given an appropriate stimulus to regression in later life, the way is open to a sweeping reflux of narcissistic energies which activate early experiences of corporeal frustration. In the face of this towering wave of regressive energy the mental apparatus is powerless. Psychic annihilation is threatened and the fateful depressive defences are called into operation.

One further misapprehension must be corrected before proceeding to outline the working of pathological introjection. It is the slipshod habit of some writers to describe conditions in which primitive love and hate attitudes are found in close or alternating relations as states of primitive *ambivalence*. Study of primitive alternating or cyclical states, e.g., of excitation and discharge, of frustration and gratification, of psychic absorption and repudiation and later of introjection and projection indicates however that in early phases of development the alternations of love and hate have not given rise to that *fused* state of affect that is characteristic of ambivalence. Nor is it satisfactory to presume, as did Abraham, that in the earliest months of life the infant is *preambivalent*.

It is certainly preambivalent in the sense that it has no organised object relationships, but it is equally certainly subject to violent fluctuations of emotion. The *cyclical form* of manic depression is therefore a regression to alternating states of love and hate, although the fleeting object attachments of the maniac indicate that the infant's early object attachments are very loosely held. Alternating states are also exploited as a defensive manoeuvre to *prevent* the development or reactivation of primary ambivalence, a state of mind which must at first be completely baffling as well as psychically painful to the infant. The cyclical nature of manic-depression is incidentally a proof that in at least the first year and a half of life no organised super-ego exists. No doubt after the first year super-ego nuclei are present but, except in the case of precocious advance, no *regulating* super-ego. Love and aggression, however expressed or experienced, are still at the stage of fighting for themselves.

A penultimate consideration! Before talking at large of depressive introjection, we must be clear as to what is introjected. Now we know that the most important introjections are those occurring during infancy when abandoned (because frustrating) objects are introjected. Later introjections can also take place but they are less significant than identifications or object relations. In the case of reactive depressions there is no doubt as to the answer. The first object to be introjected is the immediate lost, injured or frustrating, hurting or humiliating object. Moreover since the potential depressive is readily hurt the introjected object can be the object *apparently* lost, injured or allegedly frustrating, hurting and humiliating; i.e., it need not be lost in reality. The process starts with introversion of instinct but as introjection proceeds, other object investments are withdrawn and the objects abandoned for the time being. To put it simply the ego calls in its current object-cathexes and introjects the objects of these cathexes in order of importance. In cases where no obvious precipitating factor can be determined, the process is nevertheless the same. A situation of object deficiency is felt to exist and object cathexes are withdrawn in series. As the process of regression continues still earlier object imagos are abandoned until the ego, stripped bare of its object investments, is back once more at the original and primitive infantile phase of introjection. At this point the symptoms of depression make their appearance.

We are at last in a position to describe the consequences of the introjection. These depend on what happens to the introjected object and to the withdrawn cathexes. The ego has regressed to the stage where it is itself weak and threatened by Id energies, and where a primitive super-ego is the sole restraining influence. How are the primitive ego and super-ego affected by the pathogenic introjection? Originally the answer was that the introjected object introduced a fresh source of

weakness in an already weakened ego, that the libido regressed to narcissism and that the aggression directed originally to the object was withdrawn and went to reinforce the sadism of the archaic super-ego, which when turned on the ego (or to use, for purposes of description only, a most misleading phrase, on the 'new object in the ego'), thereby giving rise to a pathological state of guilt. Analysis of depressive manifestations shews however that another outcome is possible, namely, the adsorption of the introjected object to the super-ego, a condition which adds to the severity of that already severe institution: it shews also that the aggression freed by abandonment of objects increases not only the sadism of the super-ego but the sadistic reactions of the now mainly narcissistic ego. There is, therefore, a reciprocal function of ego and super-ego in depression. The super-ego attacks the ego, but at the same time attacks the introjected object in the ego: the ego on the other hand can attack the super-ego but at the same time attack the introjected object in the super-ego. With this general formula it is possible to identify the various attitudes represented in the manic depressive sequence.

At first sight the depressive patient seems to dramatise the statement 'I hate myself and if somebody doesn't do something about it I shall end by destroying myself'. But on closer inspection it can be seen that whether or not his condition is precipitated by actual loss of love from the external world, the depressive reacts *as if* he had (psychically) 'taken into himself' an object he has ceased to love. In this way he repeats the infantile phase of introjecting (parental) object imagos he can no longer love except at the cost of intolerable frustration. He lives in a mental prison with those objects, hating them in himself, thereby hating himself. By so doing he reinforces the primitive aspects of his super-ego, heaping on himself reproaches which are really directed against the object(s) he formerly loved but who have now become worthless to him.

There is of course an economy of effort in this process: even in illness the ego continues to carry out its synthetic functions. The depressive ego, being already vulnerable to guilt and being also masochistic, is all the more ready to accept reproach. So when the object is abandoned (albeit introjected) the patient believes he has done irreparable injury to someone who, however inadequate, was from time to time the object of his inadequate love. This increases his guilt readiness and adds to his feelings of despair. The ensuing state of hopelessness is a more tragic version of the kind of distress a normal person may feel if he accidentally smashes an object precariously acquired and therefore of unusual sentimental value to him.

Should however the introjected object be adsorbed to the super-ego it becomes a target for the sadism of ego. The ego has now two reasons

for attacking the super-ego, first, that the super-ego itself is built up from residue of former attachments to parental objects; and, second that the introjected object has, as it were, gone over to the enemy. For all practical purposes the result is the same. To attack the super-ego is to destroy all chance of being loved by it, so that the resources of internal love are still further depleted and there is no fund of healthy narcissism to tide over the situation. The ego is caught between two fires and the ensuing panic adds to the excitations it is already so ill-adapted to bear. Here is the psychic danger point. Failing a solution by maniacal discharge the ego's last resource is suicide.

Now it should not be imagined that a four square formula of this kind gives more than an approximate statement of the unconscious organisation of depression. No case can be really understood or successfully analysed by rule-of-thumb formulations. Somehow condensed in this interplay of ego - introjected object - super-ego lies the whole history of the individual's introjections, identifications and object attachments. On the analysis of this condensation depends the accurate sub-division of depressive states. Moreover the conflict between ego and super-ego enables the depressive to dramatise earlier *inter-relations between his most important objects*. Normally, from the time the child distinguishes between its parents, it tends to build up its super-ego on the pattern of the frustrating object. In earlier stages this is always the mother object but as the infant passes through various instinctual phases the sex of the frustrating object varies. And there are periods when a rapid alternation occurs as between paternal and maternal frustrating objects. This is seen in depression when ego - super-ego conflict is exploited to dramatise *conflict between the parents*, always a source of great anxiety even to normal children. Owing however to the instability of ego institutions in the depressive, this is again a dangerous situation; for the more the ego is identified with one parental object that is hated the more vulnerable it is to attack by the other parental object, now part of the super-ego; consequently the less chance there is of feeling protected or loved. In this connection it is of some significance that in the history of depressives it is not difficult to establish that the individual as a child has for unduly long periods felt unloved or positively hated by both parents, a state of affairs which is, more often than is generally suspected, a fact rather than phantasy.

Complicated as the depressive situation may appear when set down systematically, the clinical recognition of causal factors is not so very difficult. The first task is of course to locate the introjected object. This can be done by studying the *devices used in the course of a depression to overcome stress of conflict*. As has been seen a study of the nature of delusional self-reproaches usually indicates whether the ego itself is discharging guilt or whether the introjected object (whatever its location)

is being attacked. Similarly, the reaction of the damaged ego is easy to identify. Striving to repair its narcissistic core, it follows policies once exploited in childhood. Guided by its reinforced masochism it may seek to buy off the punishing institutions by accepting punishment, no doubt in the hope that by so submitting itself it will regain some affection (from the super-ego, of course). But the sadistic super-ego being supercharged with sadism will have none of this; so the attempt ends in failure. The ego may then seek to gain peace of mind by further regression: but as the depressive's earlier upbringing has usually been traumatic, this is to jump from the frying pan into the fire. On the other hand rebellion, a device successfully employed in similar circumstances by the psychopathic delinquent, is not possible since object relations have been abandoned. The rebellion boomerangs on the ego. By observing such patterns of intrapsychic behaviour the analyst is soon able to recognise the structural alignment of the particular case.

Further information can be obtained by studying the various *modes of discharge of tension* followed by the depressive, in particular any unsuccessful attempts he may have made at *suicide*. Suicide is essentially an economic device aimed at obtaining effective relief from an intolerable state of mental tension. In this sense it is basically a symptom of traumatic psychosis involving regression to the deepest functional levels of the mind. But regression alone would not lead to such a complete reflexion (object to subject) and reversal (active to passive aim) of instinct were it not for the damage done to ego function by the instinctual vicissitudes and ego alternations described above. Similarly disorders of ego and instinct would not of themselves lead to suicide did not the child's development at early functional levels and its constitutional over-investment with primary masochism pave the way to autoplasmic discharge. For this reason studies of suicidal attempts invariably disclose a remarkable over-determination of factors. At deep levels the regression is defensive in type although it has not the psychic content so clearly manifested at higher levels. The individual repeats the pattern of 'traumatic lifelessness' exhibited by infants who suffer excessive and prolonged frustration. Even so there is an attempt to regain a more positive state of primitive narcissism of an ante-natal type, the difference between suicide and deep sleep being that in the former instance artificial devices are used, aiming at a sleep from which there is no awakening. A similar repetition is seen in the more malignant forms of drug addiction particularly by hypnotics. Also in the functional sense all suicides may be regarded as accidents of organisation. The traumatic discharge mechanism that might otherwise lead to homicidal attack operates through the narcissistic ego at a level of primary identification, giving rise to a suicidal reflexion and reversal of instinct.

At 'conflict levels' suicide may be regarded as a successful symptom-

formation having diverse psychic content. In addition to the conflict factors already described the following points may be noted. Such remnants of the ego as have not been perverted by object introjection are submitted to a final punishment by the super-ego which has at the moment of the suicidal attempt usurped all reality function. But of course the super-ego also immolates itself and so permits the dying ego a final demonstration of rebellion and revenge. At the same time the narcissistic ego achieves a kind of final autoerotic orgasm; (dying = orgasm: death = sleep).

At still higher levels more complicated motivations can be established having interestingly enough, an elaborate infantile genital symbolism. Suicide as a self-castration naturally depends on a body = penis equation. Death is also a symbolic incestuous union with both parents, being at the same time the punishment for this incestuous union, and a sign of peaceful reconciliation with the parents (represented by the super-ego and the introjected object). Between these genital levels and the more archaic functional levels are to be found a variety of pre-genital determinants. These are usually easy to recognise through the symbolic significance of the technique employed e.g., poisoning in oral sadistic types, gassing in anal-respiratory types. Apart from these infantile sexual determinants, the influence of sado-masochistic urges is of obvious importance. In such instances of self-inflicted violence the associated sexual elements although represented in the act, e.g., being run over, falling from heights, are less important than the need to discharge aggression either actively or passively. Traces of object relationship are also responsible for these forms of suicide in which the act involves suffering on the part of relatives and friends. It is as if the ego having, owing to the abandonment of object relations, suffered agonies of intrapsychic tension, recaptured at the penultimate moment some object attachment of a sadistic type. But however these various factors may be isolated, and however complicated their interrelations may be, the essential condition for suicide is that regressive energies should operate at the precise moment when all ego-defences, from the highest to the lowest, have disintegrated. Once the reflux of energy has reached earlier functional levels only external interference or supervision will prevent the suicidal attempt. The difference between hysterical and depressive suicidal attempts is not hard to detect. The hysteric has not abandoned object relationships, the traumatic precipitating factor is more obvious, ambivalence is always present and dramatisation of a naive kind is to be found. Nevertheless efficient ego defences are still present and the attempted suicide usually ends in a failure as dramatic as the attempt.

An alternative form of discharge is to be found in *mania*. The psycho-analytical explanation most frequently advanced to account for this

condition is that the conflicts between the ego and super-ego have disappeared, and that the saving of psychic energy achieved thereby is celebrated in a kind of triumph. Either the ego rebelliously overthrows the super-ego and so gets rid of its burden of guilt or, having passed through a purgatory of depressive punishment, it once more feels loved. This latter course is observed only in milder cases of manic-depression and in any event the freed ego is still pathologically narcissistic, celebrating its triumph in an orgy of fleeting and weakly held object attachments. During this orgy the original weaknesses of the infantile ego becomes manifest. The causal elements that have been described in the case of depression can again be recognised in mania together with others which in the case of depression cannot obtain expression. Nevertheless the *direction* of instinctual flow is altered. Regression, reflexion and reversal are abandoned in favour of object cathexis and active discharge. Sexual and aggressive guilts are replaced by sample actions. At this point the functional factor in mania becomes decisive. The weak ego is unable to carry through the abreaction of tonic energy: or rather, it can carry it through only at the cost of breakdown. Hence the reality sense of the maniac is just as seriously damaged as that of the depressive.

The relation of manic depression to other forms of psychosis will be considered later. For the moment it is sufficient to note that the denial of internal anxiety effected in mania is combined with a process of projection which differs somewhat in its effect from those produced in paranoia (q.v.) and which may be described as active externalisation. The most interesting correlations are those with forms of traumatic neurosis in which psychotic symptoms are present. At earlier levels acute hypochondriasis, which incidentally is a marked feature of depression, is a traumatic functional phenomenon; but it is also a consequence of pathological introjection. In other words hypochondriacal ideas and sensations are due in part to the translation of animistic phantasies and modes of thought into terms of corporeal sensation. By a parity of reasoning epileptiform convulsions are forms of traumatic discharge similar in function to the discharge functions of mania. The object-relationships in the epilepsies are, however, of a more advanced nature than those present in mania.

At higher levels we can observe the relation of manic-depression to drug-addiction, the stage of drug euphoria corresponding in many respects to the maniacal phase and the stage of abstinence to the depressive phase. At still higher levels both manic-depression and drug addiction have interesting correlations with the obsessional neuroses. Whereas, however, manic-depression can be called a guilt psychosis with intermissions of an obsessional type, the obsessional neurosis is a guilt-neurosis which sometimes shades over into a depressive phase,

less frequently exhibits paranoid crises. In the obsessional system defence against guilt is achieved through exaggeration of the mechanisms of displacement and reaction formation, the object relationship being maintained on an uneasy ambivalent basis: in mania rapid displacement is a prominent feature and to some extent reaction formation (against guilt): true object investment, however, is lost. The relation of psychotic to hysterical depression has already been indicated.

Melancholic conditions may supervene on childbirth but are more common during or after the menopause. In such cases constitutional factors are of importance but have not been very accurately determined. In involutional melancholia psycho-somatic factors of a traumatic type in particular regression to functional levels play a large part. At conflict levels involutional states represent a mixture of reactions chiefly characteristic of depression but frequently having some resemblance to maniacal and schizophrenic discharge. No *specific* conflict factors have been determined.

A diagnosis of manic-depressive psychosis and the cognate problem whether institutional treatment is necessary depend on the degree to which the stability of the ego and the patient's reality sense is impaired by his manic-depressive organisation. The risk of suicide in depressed phases and in melancholia must not be lost sight of. Where diagnosis is doubtful a combination of excessive masochism together with strong oral, skin and muscle erotism is significant. The same may be said of a history of early hypersensitiveness to sensory stimuli and emotional crises, particularly of frustration. Where true depression is suspected considerable diagnostic value can be attached to stereotyped emotional reactions. In their prodromal phases depressives are acutely sensitive to hurt or neglect and have violent reaction formations against ideas of injury, e.g., to animals or children; although they often dominate and bully children emotionally on the ground that it is 'for their own good'. In this respect they resemble hysterical types with whom, as has been indicated, they have other affinities. The hysterical reaction formation is, however, more capricious and concentrated on a few *imagos* of emotional significance, whereas the early reaction formations of the depressive are more widely and thinly spread and also more constant.



## 2. SCHIZOPHRENIA: DEMENTIA PRAECOX

It is customary for psycho-analytical writers to proceed from a description of manic-depressive psychoses to an account of paranoia. This is usually justified on the ground that 'introjective psychoses' can be conveniently contrasted with 'projective psychoses' or paranoias. This habit is responsible for many misunderstandings. It is true that both descriptively and functionally the *mechanisms* of introjection and projection form a sharp antithesis. But mechanisms are essentially economic instruments of the ego and do not provide a satisfactory *basis* for clinical classifications. For example, because on the one hand projection is an inevitable consequence of narcissistic organisation, is in fact a mechanism that cannot of its nature give rise to elaborate ego-modifications or indeed to elaborate concepts of object relations and because on the other hand introjection is closely bound up with vicissitudes of object-isolation, object-choice and object-abandonment, thereby adding greatly to the complications of ego structure, it is commonly maintained that the fixation points of paranoia are set at a much earlier (more primitive) phase than those of depression. As will be seen this is a metapsychological misunderstanding.

Actually study of manic depressive disorder is not only a useful preamble to but a prerequisite of research on that omnibus group of disorders variously described as dementia praecox, 'process psychosis', hebephrenia, catatonia, schizophrenia, schizophrenic 'episodes', dementia paranoides, paraphrenia and the like. The regressions observed in the depressive phase of manic depression and the attempt to recapture a multiplicity of object relations characteristic of the manic phase are again encountered in what for the sake of convenience will be referred to as schizophrenia. But these regressions and restitutions do not stand in the sharp contrast of alternating states. Indeed in a schizophrenia that is only moderately advanced and therefore capable of fluctuation in response to the world of objects, regressive and 'progressive' aspects are either merged or exhibit a rapid fluctuation *within the total symptom picture*. This fact together with the observation that in some transitional forms of manic-depression catatonic states may make their appearance suggests that in any psycho-analytical approach to schizophrenia, the etiology of manic-depression must form the spearhead of the attack.

This however is not enough. It is also necessary to establish what might be called a *metapsychological base of operations*. In the case of manic-depression it was pointed out that the first step in clinical classification and in treatment is to discover the location of the pathogenic introjection (the so-called 'new object in the ego' or, alternatively

in the 'super-ego'). It is at this point in the depressive process that the patient's sense of reality-proving becomes faulty and first gives rise to characteristically *psychotic* thought or behaviour. In the case of schizophrenia more extensive investigations are necessary. It is not possible to establish *one* point at which reality-proving breaks down. Not only are the fixation points in any one case multilocal but these points vary in the different (so-called) sub-groups of schizophrenia. *This means in effect that we must discover in each case the 'general fixation level' of the ego as well as of the infantile instincts.* In other words it can be assumed that the final infantile level of ego development in the schizophrenic constitutes a base line, regression to which will, given an excess of excitation, disrupt the faculty of reality proving. Having established this base line it is then possible to distinguish between manifestations of further regression from reality (the object-world) or of a fresh advance towards the object world (reality). It is a common habit to describe the manifestations of a fresh advance as 'restitution products'. This is an unfortunate term and is often confused with the *restitution mechanisms* observed in states of obsessional guilt. From the developmental point of view the term 'progression' would be more appropriate but would involve, as in the case of 'repression', attaching a specific connotation to the term.

At this point the real objection to the use of the term 'schizophrenia' can be made clear. This is not so much that from the descriptive point of view the term is both superficial and grossly inadequate, but that it is undesirable to use a generic term for a number of conditions that vary widely in level and distribution of fixation points and therefore vary widely in clinical manifestations. Even as a descriptive term schizophrenia would apply much more appropriately to hysterical dissociation. Admittedly symptoms of different subgroups of schizophrenia have many points in common, in particular the association of massive and inappropriate affects with a conglomeration of apparently absurd ideas and bizarre actions and mannerisms; but this clinical resemblance is misleading, suggesting as it does that the basic etiological factors are identical in each subgroup. Naturally there is a good deal of overlap between the disordered products traceable to early levels of development. But it is a much better policy to discriminate between different levels of these early stages than to be content with indicating their similarities of function. No progress can be made in analysing early layers of mental development so long as schizophrenia is regarded as a clinical or etiological entity.

On the other hand it would be absurd to pretend that in the case of schizophrenia precise correlations have already been established between clinical and etiological data. Hence in the following presentation the practice followed earlier of giving a separate account of

clinical and etiological aspects has been abandoned. It is sufficient to trace the general process of symptom-formation, and to isolate these functional and purely psychogenic aspects concerning which dependable information is available, giving at the same time some account of the psychic content associated with different phases and mechanisms.

*Symptom-formation in schizophrenia.* In schizophrenia as in the other psychoses it is convenient to start by comparing the processes of symptom-formation with the standard pattern established by Freud for the psycho-neuroses. Here as in all other psycho-pathological states correlation must be effected between somatic disposition, psychogenic predisposition and the nature and intensity of precipitating factors. Many observers are intimidated in their approach by the belief that in the last resort somatic factors are decisive for the schizophrenic disposition. But so in a sense are the somatic elements and/or 'compliance' operating in the psycho-neuroses, the traumatic neuroses, and the anxiety neuroses, in fact in the psycho-somatic states generally. No doubt the not very clearly specified or established factors in schizophrenia (e.g., the effect of endocrine and vegetative disturbances on cerebral function and consequently on the innervations that promote discharge of excitations either directly or by reflexion through the vegetative system; or for the matter of that, the effect of primary cerebral dysfunction) vary with the type of case, as apparently they do in the anxiety neuroses, toxic neuroses, hypochondrias etc.; but in the meantime these somatic factors can be adequately represented under the heading of constitutional factors. The psycho-analyst's concern is with the psychogenic elements in predisposition; and these, as usual, must be considered in conjunction with the precipitating factors. Distinction can be drawn between precipitating factors that are due to endopsychic stress of excitation and those in which environmental factors play the chief part. Roughly speaking the relation between these two sets of precipitating factors is the same as that described for manic-depression. It is however clear that practically any variety of frustration trauma can give rise to schizophrenic regression and that the schizophrenic is more ready to react to comparatively mild frustration and to use his knowledge of symbolism to interpret apparently trivial indications of psychic danger. In other words *he reacts with excessive sensitiveness to what might be called microscopic indications of hostility, neglect and sexual stimulation.*

Clinically the factor of *internal stress* is best observed in dementia praecox where the flooding of the mental apparatus with the sexual excitations accompanying adolescence acts as a *traumatic agent*. At this and other critical periods of development schizophrenic breakdowns are common. Psycho-analysis confirms however the existence

in schizophrenia of more specific unconscious stresses particularly of homosexual libido. This accounts for the fact that in many instances where external precipitating factors are apparently wanting, closer examination shews that the immediate contacts or environmental settings of the patient have stimulated his unconscious homosexuality. Generally speaking the *external stresses* most likely to promote a schizophrenic regression are those that cause emotional traumata, anxiety or guilt, e.g., financial or domestic worries, emotional entanglements, losses or jiltings. Of the stresses caused by *somatic factors* the most commonly observed are toxic infections, pregnancy, labour and accidental mutilations.

To this general list of precipitating factors must be added one of especial significance in cases where apparently no immediate environmental stimulus can be detected. On occasion the patient or his relations may say that 'nothing happened' to account for the breakdown. Emotionally regarded the statement is accurate. Precisely because 'nothing happened' i.e., because his affective relations were actually at a low ebb and there were no reassuring signs of unusual interest on the part of external objects, the patient feels that he is being treated with indifference, coldness or hostility and abandons his object relations. A similar *negative precipitating factor* is often observed in both anxiety hysteria and obsessional neurosis.

The next stage in the process of symptom-formation is also similar to that observed in the manic-depressive states, namely, an *abandonment of object cathexes* and withdrawal into the ego of libidinal and aggressive energies formerly directed towards objects. This gradually sets up schizophrenic *regression*. As however the abandonment of object relations is from the beginning more extensive than that effected by the depressive the regression to narcissism is more profound and soon reaches levels at which reality sense is abrogated. At this point the most vital difference between psycho-neurotic and psychotic symptom constructions can be observed. *The element of compromise formation characteristic of neurotic symptom-formation is absent*. Now compromise formation is due to the existence of a faulty repression which is countered by fusing in the symptom both repressing and repressed elements. And it is sometimes said that the psychotic saves the expenditure of energy necessary for compromise formation by breaking with the world of objects (reality), and that by so doing he removes himself from the danger of being painfully stimulated by object relations. Perhaps it would be better to say that the schizophrenic regression is so far-reaching as to carry the ego beyond the point at which it can successfully effect compromises. Or again, it can be said that the 'fault' in repression is sufficiently extensive to throw the whole mechanism out of gear. Here again a resemblance can be detected

between the mechanisms of psychosis and those of functional traumatic neuroses. The psychotic cannot stem the regression by producing compromise products; repression failing, his regression stops only when he can live at an archaic level free from super-ego pressure and able to discharge Id tension more freely than the psycho-neurotic and *a fortiori* the normal person is able to do. *The symptom-formation is therefore a reactivation of archaic functions, through which conflict elements are almost totally denied.*

At this point the problem of *classification* becomes acute. Psychiatrists have generally followed the line of least resistance by adopting descriptive standards. Thus the most characteristic syndromes are observed in *catatonia* where stages of excitement, depression and stupor are easy to recognise. Next come the *paranoid forms* with their multiplicity of unsystematised and variable delusions, amongst which it is interesting to recognise, in addition to persecutory formations, a number of depressive as well as grandiose elements. The *hebephrenic* group are more difficult to differentiate and are usually characterised by alternating periods of frenzied excitement and depression, and a marked incoherence of thought. Catatonic and paranoid elements are often present. Partly by a process of exclusion (absence of ideas of reference, hallucinations or delusions) and partly on account of a characteristic feature of progressive psychic impoverishment, a fourth type can be isolated, namely, *simple schizophrenia*. In general the disharmony between ideas and affects and the condition of apathy and indifference are stressed in schizophrenia and certain associated features are given prominence, e.g., the vivid hallucinations of hebephrenia and the hypochondriacal phase of paranoid forms. Comparison with manic-depressive disorders shews that despite certain resemblances, the state of mental disintegration is much more widespread and much deeper. Affective manifestations are much more variable and the general rigidity is in marked contrast to the attitude of listless grief typical of melancholiacs. The states of impulsive excitement resemble mania but are more aimless and inchoate. The maniac who has a 'flight of ideas' may be incoherent because he is thinking so fast, but the excited dement talks nonsense (word-salad). The inclusion of delusions of reference and influence is also significant, although in contrast to true paranoid delusions they are unsystematised and diffuse. The total impression may be less that of a personality than of a collection of sporadic impulses devoid of central control, an automaton responding (perhaps by a strange fleeting smile or grimace) to intrapsychic stimuli. In so far as the schizophrenic can be said to 'lead' a life, it is a life of disorganised phantasy: he lives in a world of his own, in a dream.

Apart from indicating the existence of a widespread mental deterioration, having nevertheless some elements in common both with manic

depression and with paranoia, descriptive classifications shed little light on the psycho-pathology of schizophrenia. Indeed without some metapsychological criteria it is difficult to make sense of the manifestations; incidentally, one of the few proofs of 'successful' unconscious defence on the part of the schizophrenic. Nor with a few obvious exceptions is it possible to say with any certainty whether the symptoms indicate regression or recovery. Careful study of the early history of the patient may help to 'place' the various syndromes; but as early history requires interpretation and is usually far from complete, no great progress can be made along this line. Under these circumstances three methods of investigation are available (1) to distinguish between 'symptoms' consequent on regression and 'signs' of an attempt to regain reality relations with the world of objects (2) to sub-divide these regression and 'progression' products in accordance with known stages of early mental development (3) to compare and contrast the etiological factors in schizophrenia with the lesser regressions of depression and paranoia. For purposes of systematisation the most convenient course is to follow the scheme of symptom-formation formulated by Freud.

A first step in classifying schizophrenic manifestations is to isolate *indications of abandonment of object relations*. This is not just a theoretical consideration. The history of a maladapted and 'shut in' childhood disturbed by sporadic outbreaks of anxiety and excitement of the tantrum group, taken in conjunction with early signs of adolescent deterioration, in particular incapacity to feel interest or affection accompanied by great anxiety and feelings of need of love and help, clearly indicate that the schizophrenic deterioration is due either to a developmental failure to achieve normal object relations or to an acquired anxiety concerning object relations. This is borne out by the frequency of ideas of world destruction or catastrophe, in less severe cases, a feeling that the world is strange, cold, alien, empty or dead. That the world symbolises object relations is seen in the delusion that persons once of psychological importance to the patient have died. For the same symbolic reason the first signs of attempted restitution of object relations are ideas of world-saving, of personal salvation or rebirth and of 'utopian' systems, e.g., phantastic schemes of world order or government, religious manias and the like.

The next and more difficult step is to isolate *regression products* and to classify them according to their developmental level. Amongst the earlier products of narcissistic regression *hypochondria* and *depersonalisation* figure prominently. In both instances the level of the disturbance varies. Some degree of depersonalisation is due to the disturbance of object relationship, (shrinking of the more organised ego) but very soon the regression of the ego reaches levels at which the archaic corporeal nuclei of the ego are reactivated. Narcissistic cathexes

of organs are greatly increased and give rise to hypochondriacal sensations which are then 'accounted for' by primitive (animistic) phantasies and so pave the way for hallucinatory experiences and delusional ideas of possession, injury or loss due to external action. Where ideas of organ loss predominate, feelings of depersonalisation (lack of organ sensation, feeling that parts of the body 'do not belong' or are dead) develop more rapidly. But as a rule depersonalisation follows a phase of hypochondria and is a defence against the fear of organ change or loss. The patient uses up large quantities of narcissistic energy in a meticulous concern with his bodily sensations and functions and ends by producing a primitive kind of anticathexis which obliterates the painful sensations. Developmentally regarded it is possible that these early corporeal anticathexes are the prototypes of actual repression. In this connection it is of special interest that the obliteration of infantile genital cathexes plays a special role in the state of depersonalisation.

A further outcome of regression is *inflation of the ego* giving rise to feelings of grandeur and delusional formations of a megalomaniac type, (e.g., of being God). This is often explained as a reactivation of an infantile 'stage of omnipotence' existing before object relations are developed; but it seems likely that a number of factors combine to bring about the condition; (1) hypercathexis of a weakened and disintegrating ego, (2) an effort to compensate for the loss of object relations (3) freedom from the oppressive and inhibiting action of the super-ego. In this last respect the condition has some resemblance to the ecstasy and hyperactivity of the maniac. On the other hand delusions of grandeur mark the regression as being deeper than that of manic-depression. There is no sign of a dominating pathological introjection, and an organised system of self-reproach. The alterations in the ego caused by regression are much more diffuse and exhibit frequent changes.

Still deeper symptoms of regression are observed in the syndromes of *hebephrenia* and *catatonia*. The symptoms of inhibited depression together with vivid hallucination and bouts of frenzied excitement or again of automatic obedience, echolalia, echopraxia, negativism, mutism and stupor suggest at first sight that the schizophrenic has made a complete regression to an infantile objectless phase. But this impression is somewhat misleading. The schizophrenic's break with reality is usually slow and gradual. Object relations are not abruptly abandoned as in the more traumatic reactive depressions and a certain amount of fluctuation in object cathexes exists. In any case residual object relations are usually present: the patient may make contacts which though fleeting and casual in nature may sometimes exhibit either intense tenderness or hostility. These are more marked in the 'progressive' phases of schizophrenia, but a good deal of negativism

and mutism observed is merely a form of hostility towards residual objects. Even in stupor the regression is not to be interpreted as 'intrauterine' or as the repetition of an immediately post-natal vegetative reaction but as the result of a combination of abandonment of object cathexes and of effective repudiation of objects. These conditions can be better understood as functional phenomena aimed at preserving the schizophrenic from any further (dangerous) stimulations from the world of objects. *At this level the reactions correspond closely to the defensive inhibitions observed in the more serious cases of traumatic neurosis.*

From the point of view of direct psycho-analytical interpretation the most fruitful approach to schizophrenia is through the study of *stereotypies and mannerisms of speech, action and affect*. These can be roughly divided into archaic symbolical forms and forms dramatising or expressing concepts which would normally evoke conflict. Generally speaking the archaic forms are regression products, e.g., some of the catatonic stereotypies already mentioned; whereas the conceptual stereotypies indicate some degree of object contact. Following this line of approach stereotypies can also be divided into (1) indications of the nature of the early ego and of its instincts (2) indications of the early forms of infantile object relationship. This permits a further classification in terms of early ego-nuclei, balance of various component impulses and *aim* of early object relationships. Recognition of different groups of stereotypies and mannerisms of action, speech and thought is sometimes easy to effect, as in the case of eating and excretory peculiarities (coprophilia, incontinence, smearing, etc.); but particularly in the case of speech stereotypies it is necessary to employ psycho-analytical interpretation to uncover their meaning. The object of the interpretation should be, however, to isolate either primitive ego systems dominated by one or other of the various components instincts or primitive forms of object investment. With a little practice it is possible to establish in order of pathogenic importance the various ego-nuclei (oral, anal, skin, muscular etc.) disorders of which have combined to establish the schizophrenic disposition. Confirmatory evidence can then be obtained by study of the history of early character formation. As a rule the schizophrenic has shewn early signs of a 'schizoid character', although in many instances these eccentricities should be regarded as early forms of schizophrenic breakdown.

As has been emphasised the main difficulty in studying schizophrenic manifestations is to determine whether they are regression products or signs of restitution of object relationships. This difficulty is best exemplified in the case of peculiarities of *speech*. One of Freud's most valuable contributions to psychiatry was his explanation of schizophrenic speech peculiarities. According to Freud the earliest form of



mental presentation is a concrete 'thing presentation' to be distinguished from the 'word-presentations' which develop when the infant is able first to apprehend the meaning of speech and later on himself to speak. Word-presentations form the basis of conceptual thinking. Briefly Freud's theory is that *having abandoned his objects, the schizophrenic seeks to regain them through the channel of word-presentation*. A similar phenomenon is observed in normal people where words (of hate or love) are sufficiently 'affect-toned' to play the part of a concrete activity or relationship (c.f., obscene words, oaths, etc). Herein lies the secret of the phenomenon known as omnipotence of words (and thoughts). As however the schizophrenic has regressed to a level at which primary unconscious processes operate more freely, the mechanisms of condensation, displacement, over-determination, klang association, punning, elliptical reference, dramatisation, symbolism, (in short the processes that are responsible for 'dream-work') combine to produce the distorted products of schizophrenic thought and speech.

Similar considerations apply to the *hallucinatory and delusional products* of schizophrenia. The schizophrenic, having abandoned object relations in order to avoid dangerous stimulation from the outside world and having taken steps to block reality excitations, is in the position of the child that falls asleep. His psychic stimulations now come from within, and, reality gratification being barred, make a regressive movement from the motor to the sensory end of the psychic apparatus, giving rise to the phenomenon of hallucinatory discharge, and hallucinatory wish fulfilment of a form that closely resembles dream-formation. Hallucinations lend themselves to the most primitive forms of sensory thinking, (sight, taste, smell in particular) but are supported (accounted for) by the development of delusional conceptual thinking (delusions of reference etc). Study of paranoid delusions (see paranoia) indicates very clearly, however, that the delusional system is not only derived from a formerly repressed form of object relationship (homosexuality) but represents the continuance or re-activation of the wish for that relationship and so constitutes a form of object redemption. As in the case of stereotypes, the more bizarre forms are held to be regression products. But this is not a very satisfactory generalisation. All one can say is that the more bizarre the form the more it is necessary to interpret its symbolism in order to identify the level of development disturbed.

On the other hand the nature of early instinctual drives is often very plainly manifested in schizophrenia. Wishes for incestuous intercourse either positive or negative (homosexual) are openly expressed; and in the more frenzied states the traumatic discharge (homicidal and suicidal attempts, self-mutilation, sexual assaults, refusal of food, bulimia, coprophilia and smearing) indicates plainly not only the original forms

of aggressive impulses but the infantile sexual components with which these are more closely associated. These impressions are confirmed by interpretation of the speech products, and creative systems of world order in which symbolisms of the family setting and of infantile sexual object wishes are not hard to trace. The more autoerotic elements are also manifested either in patent masturbations at varying levels or in the various forms of schizophrenic invention, (the 'machine' = the body or genitals). Some forms of depersonalisation are in fact due simply to an increase in homosexual libido which by altering the unconscious sexual valuation of body organs sets up a preliminary hypochondria and then a feeling of body loss.

Nor is it always possible to distinguish between regression and restitution products by reference to what might be called *affect-stereotypies* or to affect equivalents. As has been pointed out catatonic stereotypies are generally regressive in nature but there are some which represent efforts to regain object relationships. Thus the catatonic grimace or fleeting meaningless smile is certainly a denial of object relationship or affection but it is also a first step towards object attachment. It is also an affect equivalent, a substitute for or delegate of an emotional feeling towards objects. The same can be said of many stereotypies and mannerisms, the echolalias and echopraxias. The schizophrenic thereby repeats the mimetic stages of infantile development which exist just before permanent object attachment develops. Moreover the standard affects of the schizophrenic do not constitute a reliable guide to the nature or importance of the associated mental content. Not only are most schizophrenic affects inappropriate to the mental content but the affects observed in the regression may not differ very much from those manifested during the stage when objects are beginning to be re-catheted. Great anxiety may be shewn in both stages. In the regression phase this is due to fear of excessive Id excitations (a quantitative and qualitative factor): in the stage of restitution the fear is due to the fact that reality was originally a predominantly painful experience (as indeed it is even in normal childhood). When therefore the schizophrenic begins to grope towards a new reality he re-experiences this old dread. This gives a wider conception of the defensive function of schizophrenia: *it is at the same time an attempt to ward off the dangers of reality stimulation, to discharge dangerous Id excitations and to escape the oppression of super-ego control.*

Incidentally these observations should serve as a warning to child investigators who are only too ready to attach adult significance to the affective expressions of sucklings. The fleeting smile of the infant which charms the observer and convinces her (for this is usually a mother-bias) of the angelic nature of her offspring, is either a narcissistic

celebration of the recognition of (wish)-cause and (pleasure)-effect or a bribe to bring about further demonstrations of wish magic. Often it is merely a discharge phenomenon. Similarly with the sad expressions of infants, these are either narcissistic demonstrations of the recognition of (wish)-cause and (pain)-effect, or a bribe, or again a discharge phenomenon leading if the need persists to tears and screams (tantrums).

The conclusion to be drawn from the above survey is that it is difficult to draw a sharp line between regression products and restitution products. This is not unnatural, particularly in view of the oscillations that occur during schizophrenic states. Moreover, even the crudest and most bizarre products do not necessarily indicate deep stages of regression, since the operation of primary unconscious processes itself distorts and condenses the various elements. A plain Oedipus conflict can for example be effectively disguised in a conceptual stereotypy or a schizophrenic invention. On the other hand it is clear from a study of schizophrenic products that any level of instinctual organisation, incestuous, homosexual, anal-, urethral- and oral sadistic and any level of narcissistic libidinal organisation (e.g., organ libido) shares in the regression. To effect the most essential distinctions therefore it is necessary to establish in each case what has been called *a base line of ego fixation*.

Study of transitional forms of manic depression in which schizophrenic elements appear and of the paranoid forms of schizophrenia clearly indicates that in the majority of schizophrenics the fixation level is well below that of depression. And since in the latter case the ego level of regression lies between the stage of secondary narcissism and that of organised and synthesised super-ego formation, it seems probable that *the general level of schizophrenic regression lies between the stage when primary narcissism is first differentiated by the laying down of ego-object nuclei and the stage when super-ego nuclei are deposited but have not yet taken effective control of instinct regulation*. There are a number of considerations which support this view, in particular the absence in schizophrenia of pathogenic introjections of the depressive type, the diffuseness and variability of the disorder and the regularity with which ideas of reference and other projection phenomena appear, suggesting as they do that super-ego formation has not been organised, that super-ego nuclei regress freely to that pre-stage when inhibition and interference come from without, i.e., from objects. In addition to which the scatter of elements of ego-disorder and the existence of hypochondriacal symptoms or accompanying depersonalisation suggest that although the schizophrenic ego has weathered the stage of body-ego formation he has not weathered the more advanced stages of object formation. Variation in discharge

phenomena of the traumatic type also suggests that in addition to a somatic (organ) disposition, the schizophrenic has suffered early traumata at a number of libidinal points in his ego organisation and has endured severe frustration, both real and imaginary, from the world of (familial) objects. *In this sense schizophrenia is a true traumatic psychosis.* Many of the violent outbursts observed are merely reactive forms of discharge carried out by a mental apparatus that has lost central control.

On the other hand the existence of well defined sub-groups of schizophrenia which despite much overlapping follow a recognisable course, together with variation in age and acuteness of onset warn us against accepting too rigid fixation formulae. Difficulties in differential diagnosis and in etiological formulation can best be settled by combining a psycho-analytical survey of the clinical features with a close investigation of early history and character formation.

### 3. PARANOIA: PARANOID STATES

Regarded from the developmental point of view paranoia is the most obscure and puzzling of the psychotic states. Indeed there is no better approach to the subject than to study the historical development of the psychiatric concept. Here a number of tendencies can be observed; first, to isolate a characteristic clinical entity, i.e., true paranoia, second, to outline a group of conditions having a predominantly paranoid structure, some elements of which may, however, be found in other psychotic states; third, to emphasise the paranoid aspects of schizophrenia; and fourth to stress the schizophrenic aspects of paranoid conditions.

On the whole psycho-analysts are ready to accept psychiatric distinctions of paranoid schizophrenia, paraphrenia and paranoia; but for a number of reasons they are concerned less with clinical distinctions than with the structure and function of the paranoid symptom in whatever setting it may be found. This has inevitably led to a concentration of attention on the delusional aspects of the condition; and in fact the analyst takes kindly to a sub-division in terms of delusional content, e.g., delusions of reference, persecution and jealousy, also erotomaniac, litigious, religious and grandiose products. These, he maintains, give some idea of the original fixation points to which the ego regresses and the level of object relationship to which it endeavours to return during phases of restitution. Additional evidence regarding the nature of the regression can be secured by observing the degree of hypochondria, of hallucination formation, of systematisation of delusions and the existence of deterioration products.

The facts that both paranoid and depressive features can be observed

in some schizophrenic states; that in some depressive states a paranoid element is barely concealed; that there is, nevertheless, an antithetical relation between depressive and paranoid conditions; also that grandiosity can occur in schizophrenia, mania and paranoia, are regarded by the analyst less as sources of clinical confusion than as an indication that *the psychoses include a multiplicity of disordered states having nevertheless a precise relation to the early nuclear phases of development of the individual ego*. At the same time it is impossible to ignore the fact that even in the most disconnected and unsystematised psychotic products there is a certain orderly disorder, also that both in manic-depression and in paranoia not only can characteristic and fixed patterns be recognised but the disease follows a characteristic and predetermined course. This places the psycho-analyst under obligation to provide a precise etiological formula for each recognisable syndrome, and at the same time to account for transitional and variable forms.

Although at present this task is beyond his compass it is possible for the analyst to give a general account of the etiology of paranoia, which for this purpose can be described as a chronic state, insidious in onset, characterised by fixed delusional systems, with or without hallucinations, psychically encapsulated and clearly distinguishable from the rest of the personality which may not only exhibit undisturbed ideation, volition, speech and action but retain its integration for prolonged periods without symptoms of deterioration.

It requires little reflection to realise that a condition in which the ego retains a considerable degree of integration, much greater indeed than that obtaining in manic-depression, but which nevertheless in certain respects exhibits a disruption of reality sense similar to that of the schizophrenic, calls for two distinct forms of developmental correlation. Not only is it necessary to discover *fixation points at both deep and superficial levels* but to trace the mechanisms whereby the diseased process is, as it were, *canalised and finally encapsulated*. It is for this reason that paranoia constitutes one of the most puzzling of the psycho-analyst's problems. To account for the condition he is compelled to reverse his usual order of approach, to concentrate first on developmental factors, then on the symptom-process and finally on the nature of precipitating factors. To follow a structural analogy, he must make a series of transverse sections of the mental apparatus in order to establish fixation points and a series of vertical sections to account for the integration of the ego.

This task is greatly facilitated by *clinical observation of the anxiety reactions of infancy* and by direct analysis of anxiety states occurring in three to five year olds. When the mechanisms governing these reactions are identified it will be found that they are in many respects similar to these observed in paranoid states. Most significant in this

respect are the primary phobias of infancy, e.g., of being alone (subject to danger), of darkness, noise, food, and of strange objects. To the extent that the infant behaves as if it were in danger, and that this reaction to danger coincides with conditions which (according to the observer) predicate instinctual over-excitation, it may be said that there is a family likeness between primary phobias and paranoid delusions; nevertheless the observer is not entitled to assume, as is sometimes done, that the infant is in a 'paranoid phase'. The most he can say is that over-excitation gives rise to *automatic attempts at discharge* by which an internal 'pain' (danger) is treated as if it came from without rather than from within. This tendency which is the *prototype of the mechanism called projection*, is fostered by the state of primary identification in which no clear or permanent distinction exists between the narcissistic ego and (what the observer knows to be) the infant's objects. Moreover during this early phase the phenomenon of hallucinatory regression which is used to deal with wish-frustration can also be exploited to deal with the danger (threatened pain) of over-excitation i.e., the danger is *visualised* in external form. This primitive projective tendency can for the sake of convenience be called primary projection: nevertheless *true projection (projection proper)* cannot exist until the infant has advanced to the stage of permanent object recognition, i.e., until primary identification gives place to recognition of the distinction between ego and object, a process which involves at the same time the delimitation of a body-and-organ (narcissistic) ego.

In the case of the later (*hysterical*) *phobias of childhood* the situation is more complicated. By this time the child has developed an organised system of object relationships and has experienced (recognised) the frustrations and dangers actually proceeding from external sources. When therefore he endeavours to escape from the over-excitations of frustration (increased now by reactive rage against the frustrating object) *he regresses to the earlier phase when he sought to discharge traumatic tension by a primary projection*. But as he does not abandon object relations, *his projections are directed towards the object*, which now appears to threaten him more than it actually does. This is a state of affairs which first justifies the description of projection.

And here we have the first reliable clue to the nature of 'paranoid' projection. Whereas hysterical phobias are ranked as psychoneurotic symptoms (a) because they represent compromises between the repressing and the repressed (b) because the patient does not abandon object-relations and (c) because he recognises the irrational nature of his anxiety, paranoid delusions rank as psychotic (a) because there is only a marginal compromise between repressing and repressed forces, (b) because the patient abandons object relations in so far as these threaten frustration and danger and (c) because he is convinced of the

truth of his delusion, i.e., his reality sense is suspended or abrogated *in respect of the particular complex involved*. Moreover his efforts at projection are more strenuous than those of the psycho-neurotic. In his efforts to get rid of the instinctual stress which in the last resort is responsible for his frustration and consequently his over-excitation he is convinced that the instinctual urge is directed at him from the external world.

Admittedly both normal and neurotic persons shew similar tendencies e.g., they may be inclined to feel ill-used by a hard world, may be acutely self-conscious on social occasions and have ideas of reference. Indeed the normal lover not only over-idealises his object but projects his own reactions and wishes on her. Nevertheless the reality sense of such individuals though diminished is not pathologically disturbed. On the other hand the individual who believes without any real grounds that there exists among the members of his family a conspiracy to poison him or imagines that every woman he encounters tries to accost him, is psychotic. No doubt the paranoiac might plead, if he were so disposed, that after all he has some justification for his complaints; that strangers do harbour hostilities to other strangers and have casual sexual impulses towards them. In other words the paranoiac does not project, as it were, into the blue: *there is always a minute kernel of truth in his affirmations*. In the first instance, he *interprets* the unconscious tendencies rather than the effective and conscious impulses of the stranger. This very capacity is of course suggestive of 'psychotic insight' and becomes definitely pathological when he goes on to interpret symbolic situations as 'real' stimuli and finally *behaves* as if *all* his interpretations were correct.

The insight into paranoia afforded by study of early anxiety formations can be strengthened by observation of various *character traits developing in childhood and adolescence*. Thus early 'traumatic' stigmata, (periods of early excitement and irritability ending in tantrums) evidence of narcissistic defence (a passionate sensitiveness and shyness, excessive pride, ambition, selfishness and secretiveness) and exaggerated reactions to objects (vanity, envy, jealousy, suspiciousness and sensitiveness to criticism) later, capricious sexual interest combined with a weakness of potency and marked ambivalence to objects of the same sex, are of significance and can be interpreted in terms of different levels of ego- and libido-weakness. A similar approach was adopted by Krafft-Ebing and Kraepelin in some of their clinical classifications. It should be remembered, however, that some variable character formations are really larval paranoid 'episodes': and in any case character estimations are vitiated by the fact that the paranoid and the schizoid character have many elements in common. Moreover it is significant that in a number of cases only infantile traits can be recognised; many

paranoiacs go unsuspected unless their delusions give rise to some type of extraordinary behaviour. Many comparatively harmless eccentrics and cranks are paranoid: they attempt to master their excessive excitations by a roughly established projection system, coming to terms with their difficulties by a mutilation of their ego. In the majority of instances, however, the impression remains of a pathological narcissism buttressed against external stimulations.

It must be admitted, however, that evidence of narcissistic regression, even if reinforced by symptoms of hypochondria, by hallucinations or grandiose delusions, does not solve the problem of paranoia. Narcissistic regression is common to all the psychotic states and varies according to the depth and scatter of fixation points, also in accordance with the degree of object abandonment. In schizophrenia the fixation points are deep and widely scattered: in depression the fixation points though deep are not scattered: in paranoia they are both superficial and deep and are even less scattered than in depression. Indeed the very integration of the unaffected parts of the ego in paranoia suggests that *some selective instinctual factor operating at both low and high levels is responsible for the final form of paranoiac symptom-formation.*

This is borne out by study of the *delusional products* in paranoia. In some instances the sexual components responsible for the disorder are clearly indicated, as when the persecuting voices accuse the patient of being homosexual and indulging sexual activities of a dirty or evil (pre-genital) kind. But as a rule delusional and hallucinatory products require interpretation. The standard patterns were outlined by Freud from an analysis of the famous Schreber autobiography. The delusion of persecution constitutes a denial of the patient's attachment to a homosexual object: it is represented in the formula 'I do not love the man: I hate him: because he persecutes me'. The persecutor is the homosexual object who, owing to the patient's interest, constitutes a constant temptation (threat). In the delusion of jealousy the patient projects his forbidden interest on to a woman: 'I do not love him (the other man): *she* loves him: hence my jealousy'. In the erotomaniac delusion the denial is represented through the formula 'I do not love him: I love her: *because she loves me*'. In litigious forms and in the more general delusions of reference, the spread of homosexual object interest is more manifest: 'everyone attacks me'.

In the litigious form, however, the *defensive aspects of narcissistic regression* are more obvious, and in delusions of grandeur they receive their logical expression: 'I love nothing and no one: I love myself alone'. Deeper regressions depend on the original order of differentiation of narcissism. It has been established for example that some of the persecutor's 'characteristics' would be more appropriately described in terms of the patient's own corporeal experience. The persecutor may



represent his own faeces or buttocks; in other words, the delusion of persecution 'accounts' for the patient's disordered sensations, particularly intestinal sensations. We might even describe this state of affairs as *an attempted projection of his hypochondria* which inevitably fails leaving only a (projected, delusional) 'theory of hypochondria'. This incidentally sheds a considerable light on the psychic factors in all forms of hypochondria (q.v.).

In fact the grading of libidinal cathexes in paranoia between homosexual and narcissistic attachment gives a clue to the mechanisms of *psychotic object restitution* which has already been recognised in schizophrenia, and in the manic phase of manic depression. It has always been maintained that homosexual fixation stands half-way between narcissism and heterosexual interest. In the sense of object relations the paranoid regression is, by comparison with the sweeping regressions of schizophrenia, a limited one. *It stops mainly at the homosexual level thereby preserving the patient from a complete break with reality.* The paranoiac first abandons his heterosexual object relations, regresses to homosexual attachments, then abandons his homosexual attachment and embarks on a narcissistic regression in which however the homosexual drive is maintained in a frequently disguised and always projected homosexual delusion. By so doing the paranoiac endeavours to satisfy his appetite for homosexual relations. In other words his delusion is an attempt to restore object relations of a homosexual type. From this point of view delusions of reference may be regarded as an attempted restitution of (casual) object relations: the patient at the same time enhances his narcissistic importance by being 'observed' by everyone and discloses his desire for total love.

Here we can recognise *a process that resembles compromise formation.* It has previously been noted that in the psychoses no compromise occurs between the repressed and the repressing forces comparable with that existing in the psycho-neuroses. And that is true enough, because the psycho-neurotic compromise formation represents at the same time an affirmation and a denial of (or punishment for) forbidden forms of object relations *which have never been abandoned. The compromise in the case of psychoses is between total abandonment of pathogenic object relations and their reconstitution in a psychotic form.* The delusion formation, accordingly, though not strictly a compromise, functions as a compromise. In paranoia, therefore, where abandonment of objects is limited, it is not so easy to distinguish between regressive and restitutive products as it is in schizophrenia, although in fact the restitutive function of delusions is best established in paranoid cases.

The homosexual significance of the paranoid symptom has frequently been called in question by descriptive psychiatrists; indeed some

psycho-analysts believe that in exceptional cases, particularly in erotomania in women, the disturbance is due to heterosexual excitation. The psychiatric criticism is due to a misunderstanding of the relation between unconscious and conscious homosexuality. As in the case of drug addiction the homosexual factor is latent. Moreover in an analysis of a case in which the patient's fixation was apparently heterosexual, Freud was able to demonstrate that underlying this construction there lay an attachment to the parent of the same sex. It will generally be found that cases apparently contradicting the general theory are female and that their symptoms can be traced to early anxiety situations in which the mother has evoked active sadistic feelings and where in consequence a violent defensive attachment to the father has followed. In any case the various elements in the Oedipus situation are so closely intermingled that even a marked negative (homosexual) complex can represent in obverse the more positive (heterosexual) elements.

Summing up the instinctual factors in the paranoid construction, it can be said that the patient's sexual constitution is markedly homosexual and consequently that anal sadistic impulses predominate. Oral, skin and respiratory components are also found but to a much lesser degree. As in other psychotic cases the instinctual components most concerned can be recognised from the symbolism of the delusional product and from the nature of phobic reactions present, e.g., poison ideas, injury by electrical waves. Traumatic experiences in the first years add considerably to the predisposition to paranoia. *The paranoid is markedly sensitive to sadistic over-excitation*, and in most cases the relations with the mother have been overcharged with sadism. Nevertheless genital attachments of a weak type have been achieved. These however are heavily impregnated with castration anxiety. In general, object relations are marked by an *acute ambivalence*. The paranoid is only partly successful in his attempts to project sadistic impulses. In his defence against the hostility that he attributes to the persecutor he employs his unprojected aggression. These active reactions may lead to all varieties of attack, ranging in seriousness according to the individual, from quarrelling, backbiting and slandering to bringing lawsuits or making physical assaults which may not stop short of homicide. In more passive cases, projection results in a technique of avoidance, as in paranoid phobias. The 'poison' paranoid may finally refuse to eat at all in his own home.

It remains to consider the *influence of super-ego formation* on the paranoid construction. In this connection two sets of observations are relevant. As has been pointed out the persecutor is sometimes endowed with the characteristics of the patient's own organs: and it is no surprise to find that he also presents characteristics of the patient's own ego, in other words, mental attitudes. In the second place, study of delusions

of reference shows that the persecuting objects appear to observe, criticise, attack (punish) and in one way or another attempt to control the patient. This state of affairs which has many resemblances to the system of delusional self-reproach adopted by the depressive indicates that the paranoid abandonment of objects is not so complete as in the other psychotic states. True, the paranoiac makes a marked regression to narcissism, but he arrests this regression at the stage when external objects perform the functions later carried out by the super-ego. The voices heard are the disapproving and hostile voices of the parents. Litigious paranoia is in this sense a reversal of unconscious guilt: the patient merely counter-attacks attacking forces. As is to be expected the paranoiac super-ego has been based on introjection of the frustrating parent (of the same sex). In the paranoiac regression, this introjected object is projected, and merges with the image of the once-loved but now hated homosexual object. The external object takes over the hostile functions of the super-ego; by the same token the once introjected but now projected object (the super-ego) is sexualised. The former pleasure-wishes (always frightening to the paranoiac) are now externalised and become painful and dangerous. *This is the paranoiac's substitute for object relations: in place of homosexual love he accepts the dangerous influences emanating from the object, which he now attacks.*

Allowing for differences due to variations in the depth of regression, and in the area of ego involved in the disordered process, the foregoing account will be found to apply to any condition in which paranoid mechanisms are present. But it does not really explain why in true paranoia the condition is, as it were, *encapsulated*, that is to say, occupies a certain area of the mind without disturbing general ego-function. It is sometimes suggested that this encapsulation is due to the process of *systematisation* which is observed in true paranoid delusions, but this is to account for one unknown in terms of another. In any case systematisations are present in the obsessional neuroses where they are set up by pre-conscious anti-cathexes of a reaction-formation type. A more fruitful suggestion was made by Freud when he pointed out that the delusion formation was a restitution product developed precisely at the part of the mental apparatus where reality relations were abandoned, at the point, that is to say, of maximal weakness in the crust of the ego.

Following this suggestion we can express the situation also in dynamic terms. Encapsulation and systematisation are both due to the fact that at the crucial point of development *well defined instinctual components are disordered*. However scattered the primitive fixations leading to early traumatic responses of a projection type, the later instinctual fixations are almost exclusively concerned with homosexual libido and the specific sadistic reactions associated with it. Should the latter

fixations be more diffuse, encapsulation is not so well organised: instead we have the condition known as paraphrenia. Should the earlier traumatic reactions persist unmodified into the genital phase of development we have the condition known as paranoid schizophrenia, with its diffuse unsystematised delusions and diffuse object restitution.

It will be seen therefore that in true paranoia *an organised (reactive, negative) homosexual ego-nucleus is responsible for the final form of the disorder*. Behind this, in stereotyped cases, lies a disordered anal-sadistic nucleus, which carries on some of the functions of introjection usually attributed to the oral nucleus in more normal persons. Introjection in the paranoiac is of an anal pattern and guilt is not only predominantly anal-sadistic in origin but in the paranoid projection is 'homosexualised'. Indeed in making a comparative survey of the psychoses it helps to place true paranoia if we regard it as a kind of *large-scale stereotypy*. But since a stereotypy is simply an organised behaviour pattern (mental or physical) *it is perhaps better to regard true paranoia as a condition in which a highly disordered ego-nucleus succeeds in occupying permanently some of the approaches to perceptual-consciousness and to motility*.

Armed with these formulations we can consider finally the nature of the *precipitating factors* in paranoia. As in the other psychoses these can be sub-divided respectively into situations of external and of endo-psychic stress. The external situations can be further classified as obvious and occult, meaning by occult that, as far as the observer is concerned, the nature of the stress can be inferred only by an interpretation of the symbolic value of the situation. It should be remembered of course that the paranoiac reacts also to minimal stimuli, i.e., the amount of floating unconscious homosexual and aggressive reaction present in all human beings. Amongst the internal factors a readiness to react with traumatic projective discharge to over-excitation following frustration is the most important. Next in order of developmental importance is an early sadistic reaction to traumatic upbringing. In the male, and the great majority of paranoiacs are male, this is in the first instance a sadistic reaction to the mother which is later transferred and canalised towards the parent of the same sex. In female paranoiacs, the sadistic reaction remains attached predominantly to the mother image.

In the case of external precipitating factors, either manifest or occult, two elements have to be taken into account, general traumatic (narcissistic) elements and specific (object) elements. Disappointed ambitions involving at the same time envy of competitors and situations causing injury to self-esteem are of importance. Similarly, unsuccessful emotional situations with objects involving envy and jealousy of rivals. Conditions of relative impotency are also important, hence the precipitating influence of either venereal disease or of a phobia of

venereal disease. Indeed some monosymptomatic phobias e.g., of baldness, are often wrongly described as hysterical: they are prodromata of a paranoid condition. But in both manifest and occult precipitating factors, the importance of homosexual excitation is paramount. In this connection it is interesting to note that in the traumatic war-neuroses, occurring under training or combatant conditions, either the manifest homosexual stimulus is exaggerated or the patient reacts to the latent homosexuality which is a marked feature of army organisation, or again to his 'infantile submission' to persons (officers) of the same sex.

#### 4. SOME GENERAL CONSIDERATIONS REGARDING THE PSYCHOSES AND THEIR TREATMENT

Reviewing the etiology and clinical form of the psychoses, some general conclusions can be formulated having a useful bearing on the developmental aspects and classification of psychological conditions. For example, in the summary of psycho-somatic and allied disorders it was pointed out that these can be traced to different levels of mental activity, a primitive level of psychic activity, a more organised functional level, a level at which psychic conflict, as distinct from symptom-formation, plays the main part and a level of 'symptom-formation' which however itself varies in depth in accordance with whether psychotic or psycho-neurotic 'symptom-formations' determine the form of the disorder. It is clear from a study of the psychoses that the constitutional and pre-disposing factors operate at the first two levels, giving rise to a tendency to discharge traumatic states of tension in symptoms which have however no specific content. When mental conflict begins to take specific form its immediate effect varies between increasing the previous tendency to discharge and developing inhibition of function. The symptoms however are still not 'symptom-formations' in the Freudian sense and carry no specific meaning. Psychotic symptoms are the earliest symptom-formations having specific content. Psycho-neurotic formations appear at a later level and have more elaborate content. No doubt 'conflict levels' also vary in complexity, some being more primitive than others, but their influence on clinical disorder is through exaggeration of inhibition or discharge. Fundamentally therefore the psychoses and the traumatic neuroses have much in common.

The second consideration involves the *influence of unconscious mechanisms on mental development and disorder*. It has been pointed out that although there is a significant antithetical relation between depression and paranoia, the real contrast lies not in the clinical symptoms, for paranoiac regression is much less extensive than the

regression of melancholia, but in the contrasting operation of two main mechanisms viz. introjection and projection. Depression is a true introjective psychosis, paranoia a true projective psychosis. The tendency to trace depression and paranoia to primitive (first-year) levels and to give developmental precedence to 'psychotic positions' in the order, paranoid, depressive and manic, is due to a confusion of thought. As study of schizophrenia conclusively proves all the *mechanisms* that later on are *exploited* in psychotic states are present at the early traumatic levels of function.

The most striking aspect of introjective and projective mechanisms, as observed in the psychoses, is their relation to the mechanism of repression. The pathological introjection of the melancholiac absorbs the energies that would otherwise be expended in actual repression. This is clearly indicated in the reactive state of mania where unrepressed and externally directed energy appears. Following this line of thought we can see that the paranoid system deals with energy that would otherwise be repressed: it does so by a regression to an infantile stage at which external inhibitory forces play the part later played by repression. One must not be led astray, however, by the pathological exaggerations of function observed in melancholia and paranoia. Study of the normal individual as well as of the schizophrenic shews that the mechanisms of introjection and projection *operate as auxiliary defences at all stages of development*. Both are present in schizophrenia: in the transitional states that lie half-way between psychoses and psycho-neuroses (the drug addictions) some forms have a depressive others a paranoid aspect. Similarly in the obsessional neuroses; some lie nearer to paranoid states, others to depressive states; although it is significant that the development of an obsessional neurosis is generally a proof that regression in that individual will never proceed to psychotic levels. Normal character-formations also manifest an introjection-projection polarity.

A third consideration touches on the relation of the psychoses to *super-ego formation*. Super-ego formation constitutes a nodal point in mental development. Intended to assist the mental apparatus to deal with the peculiar emotional and familial strains to which all human beings are subject, it nevertheless owes some of its success to the simultaneous development of the reality ego and to the exploitation of sublimation, a dynamic process which reduces excitation that would otherwise be traumatic. If these reality and sublimatory devices do not operate satisfactorily, a state of affairs which is inevitable in any individual having a narcissistic constitution and a frustrating upbringing, the existence of the super-ego itself brings about a traumatic state of excitation. In depression the 'cure' is to introject more and more thereby destroying the ego for the time being: in paranoia it is to

project more and more, thereby salving some ego-function at the cost of localised ego-distortion. This naturally has an important bearing on the psycho-therapy of the conditions.

The most valuable psycho-analytical contribution to the theory of the psychoses is that concerning the nature of normal *reality-function*. By far the most reliable indication of psychotic disorder is disturbance of the function of reality-proving: and, as has been seen, this disturbance is a measure of the degree of abandonment of objects. We are therefore in a position to indicate the function of reality-proving in terms of the relation of the ego to the objects of its instincts. *The faculty of reality-proving can be defined as the capacity of the ego to apprehend the relation of its conscious instinctual urges to the objects of the instincts in question, irrespective of whether these urges have been, are or will be either frustrated or gratified.* Obviously this is a theoretical standard to which in practice no person ever fully conforms; equally obviously it cannot apply to unconscious urges. The psychotic may be defined as a person who to a greater or lesser degree refuses to conform to this painful standard, and who at the same time substitutes for it a subjective (originally unconscious) measure of reality, clinically recognisable in delusions and hallucinations.

These general considerations have a theoretical bearing on *the psycho-analysis of the psychoses*. Taking them in reverse order we can see that the first concern of the analyst should be to discover and reduce the painful reality situation which in combination with internal factors precipitated the breakdown. In other words the psychotic person fears the world of reality, withdraws from it and tries to substitute his own reality. In many cases it is possible to infer from the delusional product which particular aspects of reality have been most threatening to the patient. With regard to the 'content' of the psychotic symptom-formation, it is sufficient to say that to start the analysis of a psychotic by 'interpreting content' is in a sense to carry coals to Newcastle: the psychotic is usually a much better interpreter than the analyst. Moreover to interpret content without dealing first with the patient's traumatic reaction to reality is to leave him at the mercy of his anxieties. Following this lead the next endeavour should be to reduce the traumatic oppressiveness of super-ego function which makes a narcissistic breakdown the only possible solution for the patient. The third stage is an attempted reduction of the traumatic trigger-mechanism that has operated from early stages of the patient's childhood. Social treatment should be based on the principles of developing anti-cathexes, but must be dosed in accordance with the patient's sensitiveness to instinctual stimulations. Other factors will be considered in the appropriate section (see Section III).

## Chapter XIII

## TRANSITIONAL GROUPS

## DRUG ADDICTION

As has been emphasised in the previous chapters, psycho-analysis is constantly concerned with the developmental aspects of mental disorder. In this respect it is closer to biology than to organic medicine. The organic physician finds it convenient to classify disorders in accordance with the organic system mainly affected; and in his text book presentations gives priority to those acute conditions that constitute common dangers to life. The psycho-analyst too finds it convenient to adopt certain clinical and systematic classifications but his immediate concern is to place the various groups in a developmental sequence. Nor is he deterred by the fact that some of the conditions described are comparatively rare. So long as they can be traced to a specific phase of development and thereby contribute to understanding of disorders arising either from earlier or later phases, he is prepared to single them out for purposes of presentation.

Now there are certain mental disorders which, although by comparison with the classical symptom-formations relatively infrequent, exhibit some remarkable features. In the first place they do not fit into the usual classifications of psycho-neuroses and psychoses. They are more intractable, at times more crippling and ultimately more disintegrating than even advanced neuroses; yet clinically speaking they cannot be regarded even as border-line psychoses. It is true that in acute phases they may exhibit transient disturbances of reality sense (e.g. hallucinations) of a psychotic type; but ordinarily their mental condition may be hard to distinguish from that of normal people. Moreover it is exceptional for these conditions to develop into characteristic psychotic states. Yet although the symptom picture is neither neurotic nor psychotic in type, examination of the unconscious mechanisms concerned shews that these are both neurotic and psychotic; or more accurately, since a mental mechanism *per se* is not a pathological manifestation, that they are operative in both neuroses and psychoses. In the absence of a better label and in order to suggest comparative 'depth' they can be described as *transitional states*; but in course of time it will no doubt be found possible to give them a designation more in accordance with their developmental origin and significance.

The conditions generally described as *drug-addictions* belong to this



transitional group. Clinically regarded they are pharmacotoxic states presenting in acute stages characteristic signs of intoxication which affect the patient's social and sexual behaviour. They also shew spontaneous periods of remission during which the individual's behaviour may appear to be normal but which on closer examination are found to be accompanied by some degree of social difficulty and a good deal of sexual disability. The term pharmacotoxic is however misleading; it deflects attention from the fact that addictions, however harmful their ultimate effect may be, are essentially spontaneous attempts to 'cure' unconscious conflicts arising from a level earlier than that responsible for psycho-neurotic symptoms and later than that associated with psychotic reactions. Indeed it can be maintained with some justification that they tend to preserve their victims from becoming clinically psychotic.

A still broader conception of the clinical status of 'addictions' can be gained by distinguishing between *malignant* and *benign* forms. Alcohol, cocaine, and morphine habits are merely the most familiar varieties of malignant addiction. Many drug habits are not only benign but cultivated by persons who regard themselves and are regarded by others as perfectly normal. Common examples are tea and coffee habits, aspirin-eating and other forms of domestic drugging, tobacco smoking and snuffing, sweet-eating and a host of other compulsive habits. Chewing habits are merely inhibited forms of addiction; with a few outstanding exceptions they belong to the benign group. Many dietetic fads are of the same order as addictions and offer an interesting contrast to compulsive aversions from certain articles of diet.

The fact that drug addicts succeed in the long run in inflicting serious injury on their physical and mental health, that many of them exhibit a marked instability of character and that they frequently suffer from psycho-sexual maladjustments has led some observers to describe them as essential psychopaths. This practice is scarcely justifiable. As the existence of benign addiction shews, the group is as closely linked to 'normal' habit as to psychopathic behaviour. Moreover the obsessional and self-injuring factors present in most addictions indicates that the operative mechanisms are on the whole *autoplastic*, i.e. they seek to resolve mental conflict by alteration of endopsychic function. The psychopath on the whole adopts *alloplastic* methods of dealing with conflict: he seeks to alter environment in a way consonant with his unconscious drives. Obviously the transient hallucinatory and other disorders of reality sense occurring during the phases of intoxication are not unlike the more chronic schizophrenic dissociations. But these manifestations do not of themselves provide the most important link with the psychoses. From both clinical and etiological standpoints, drug addictions bear closer resemblances to manic-depressive disorder.

They are *diphasic* in nature, the phase of painful abstinence corresponding to the depressive phase of cyclothymia, the intoxication phases having many features in common with manic excitement. Moreover in many instances the remissions have, like the remissions in melancholia, an obsessional character. Actually an addiction occurring in a depressive type may be a substitute for and a safeguard against suicide.

By way of contrast some addicts make excessive use of the unconscious mechanism of projection and in their remissions display suspicious and negativistic character reactions. Distinction between 'depressive' and 'paranoid' types of addiction can usually be effected by observing the mental content during the phases of intoxication and of abstinence respectively. In the paranoid type of alcoholism persecutory ideas and delusions of jealousy make their appearance. In the depressive type the intoxication phase is associated with almost maudlin self-depreciation. There is however a vital difference between true paranoia and 'paranoid' types of addiction. Whereas the persecutory paranoiac is troubled by 'external enemies' against whom he directs his aggression the paranoid type of addict employs a powerful and dangerous drug to destroy enemies who he unconsciously believes exist within himself. The place of the paranoid delusion is taken by a compulsive action, directing aggression against the self.

This element of compulsion, taken in conjunction with the complicated rituals observed by most addicts point to the neurotic aspects of drug addiction. Obsessional features are, however, more easily observed in the stages of remission. Confirmation of the close relation between addictions and obsessions is to be found in those occasional cases of obsessional neurosis which exhibit phases of addiction, usually to the milder forms of sedative. Finally the physical consequences of drug-taking (e.g. loss of appetite, gastro-intestinal upset and, in cocaineism particularly, loss of weight) function, according to the strength of the drug, as slow or rapid conversion hysterias.

The compulsive play with drugs permits a symbolic dramatisation of primitive unconscious phantasies concerning love and hate relationships with parental objects. The family fixations lie between the ages of two to three and a half years. Incidentally it is of interest that depressive states can be traced to disorders existing between eighteen months and two and a half years, while the fixation points of obsessional neurosis lie between two and a half and four years of age. On the whole, therefore, the unconscious sexual system that is activated (or protected against) in drug addiction is a pre-genital one and is associated with an overcharge of sadism. The stronger and more primitive the unconscious sadism the more malignant the form of addiction. In such cases the drug represents to the unconscious an external object endowed with the loving and hating characteristics that were originally associated

with one or other parent. A dangerous substance is chosen because owing to the projection of the individual's infantile sadism parental objects were once felt to be dangerous. The patient's attitudes to the drug is, however, ambivalent. It is hateful but necessary. It is necessary because the person feels that there is something 'bad' inside him (evil parental spirits, bad body-organs, or, more simply, anxieties and guilts due to mental conflict). The drug either anaesthetises this internal badness or, being more powerful, 'knocks it out'. But in so doing it 'knocks out' the individual. A good example of this system is the development of sleeping draught addictions in cases where the drugs were taken originally in order to annul anxiety in insomnia.

In the less severe forms of addiction the fixation situations correspond fairly close with those found in severe obsessional neuroses. *An unconscious homosexual constellation is invariably present.* This is easiest to observe in the case of alcoholism in men and it is not without significance, that in ordinary social and ceremonial drinking, a good deal of homosexual libido is loosened, as in the stag party. The sadism present although primitive enough is not so pathogenic as in deeper types. As might be expected hysterical patterns are also to be found; and in such cases the drug ritual is very obviously determined by phallic symbolism. Unconscious pregnancy phantasies are also common. In other words the drug represents to the addict's unconscious either the penis or the semen of the father. This factor of symbolism is often useful in distinguishing different types. In the more severe pre-genital forms of addiction it is not difficult to establish that the drug symbolises mainly excretory substances.

Unfortunately it is not always possible to determine the depth of the disorder from the nature of the drug used or the form of drug technique. Obviously the various components of infantile sexuality influence the unconscious choice of agent. It is not difficult to recognise the profound influence of oral erotism and oral sadism in all drug addictions, but in some cases anal and urethral sadistic impulses seem to be even more decisive. An interesting group is constituted of persons addicted to chloroform, ether or nitrous oxide inhalation. Here factors of respiratory and anal erotism are decisive. Unconscious genital (castration) anxieties are prominent particularly in those addictions involving piques. In the average case the sadistic elements are derived from oral, anal and genital phases of development. This sadism is projected, focused and localised in the drug. The taking of the drug then represents control of the dangerous substance by incorporation. At the same time the euphoria or the relief from anxiety and guilt produced by the drug is a proof to the unconscious mind that it is a more reliable source of pleasure and therefore of love than the real parents were in their time. These unconscious interpretations are part

of an animistic system. They depend on the unconscious theory that an evil spirit or object, however damaging, can best be restrained by taking it inside the body; and that true love consists in swallowing the love object. The system whereby libidinal and sadistic attributes are displaced to and focused on an inanimate object is reminiscent of the displacements observed in fetishism (q.v.). And in fact many fetishists pass through phases of drug addiction. In the true drug addiction, however, manifest libidinal reactions to the drug are rarely manifest, though the attitude of the patient to it is akin to a state of infatuation. Many addicts indicate this by a phobic reaction to the absence of the drug. They carry it with them in pocket or handbag not so much for emergency consumption as to avoid the anxiety of separation from the symbolic love object.

Assessing the various psychogenic factors from the point of view of prognosis and treatment it can be said that the most important correlation is that with depressive and persecutory states. So striking is the resemblance that it has sometimes been thought desirable to make depressive and paranoid features respectively the basis of a clinical subdivision. And although this is to push a resemblance too far there is no doubt that a distinction of this sort is clinically useful. For instance, although abstinence is easier to induce with some drugs than with others, e.g. with cocaine than with morphine, rapid abstinences should not be embarked upon before discovering, not only the clinical type of the addiction, but the protective functions performed by it. For practical purposes three main types can be distinguished. The mildest forms are those due to reinforced unconscious homosexuality. Next come the addictions with a cyclothymic organisation. Cases of this type are inclined to favour frequent self-imposed abstinences. By way of contrast the third or paranoid type of addiction is more chronic and shews only occasional spontaneous remissions. Differential diagnosis is not difficult. In the first type heterosexual inhibitions are frequently present and the patient's social habits confirm the impression of unconscious homosexual imbalance. Such cases either shew an over-convivial disposition in the company of men or they are extremely shy with men. Paranoid types tend to secret drinking. Depressive types usually shew abundant evidence of excessive unconscious guilt. In all cases the tendency to relapse is strong although occasionally spontaneous recovery may take place usually when, after the lapse of years, organic sequelae take over the symptomatic functions of the original addiction, in particular when they are severe enough to satisfy the unconscious need for self-punishment. A similar outcome can be observed in addicts who develop in middle age some serious form of illness or suffer some real or imaginary loss.

Although the types described above are the commonest forms of

addiction met with in general practice, the family physician has many opportunities of observing social forms of habituation which although not strictly speaking 'drug habits' are nevertheless significant pointers to mental balance or to possible mental breakdown. This is especially true of social drinking. Two groups in particular are worthy of attention, those whose psycho-sexual life does not run smoothly and those who shew some of the social stigmata of unconscious homosexuality. Impotent men and frigid women have frequent spells of excessive drinking. The condition usually goes undetected because of the cover for heavy drinking provided by social custom. Persons suffering from conflict over unconscious homosexuality often take to heavy drinking about the age of thirty. This is particularly noticeable amongst those whose occupation encourages 'treating'. Fundamentally dissatisfied with their existence, they cultivate brittle social relationships, are frequently promiscuous in sexual habit and exploit a superficial *bonhomie* with the help of alcohol which up to a point keeps their unconscious anxieties and depressions at bay. Some of these cases develop a true anxiety depression with hypochondriacal features when in the forties. This is usually heralded by diminution or loss of potency. It is usually thought that the impotence is a direct result of the excessive alcohol intake. This is however a misreading of symptoms. Unconsciously most of these individuals suffer from sexual inadequacy and seek to conceal this fact from themselves by indulgence in promiscuous sexual activity. The appearance of impotence, or in the case of women of frigidity, merely indicates that the underlying regression has taken a turn for the worse. The earlier such cases can be induced to undergo a psychological examination the better.

Although the group of drug addictions is not a large one, it is difficult to exaggerate its importance for the understanding of mental disorders in general. It is desirable therefore to recapitulate its transitional characteristics. Unlike the psycho-neuroses, drug addictions manifest a wide scatter of fixation points mostly of a pre-genital type. Consequently the Oedipus-system involved can be described as a mainly pre-genital Oedipus nucleus. But although in this respect the drug addictions are closer to the psychoses they exhibit much more ego-synthesis. Their major fixation points lie at a more advanced stage of development, between the phases responsible for melancholia and paranoia and the phase responsible for obsessional neurosis. This applies, of course, more to malignant addictions. The essential difference between a severe and a benign addiction is that in the latter case genital elements have attained some degree of primacy.

The problem of drug-addiction cannot be solved however by thinking of it exclusively in terms of libidinal organisation. It is clear from analytic investigation that in malignant addictions the variety of

unconscious sadism also determines the severity of the habit. Anxiety manifestations and masochistic crises are much more obvious in such cases. This combination of anxiety factors and sadistic factors has a significant bearing on the relation of drug addictions both to melancholia and to paranoia (q.v.). Within his 'system' the paranoiac has a much wider range of anxiety reactions. His whole object-world threatens him. The drug addict to some extent salvages his object-relations by concentrating his anxiety reactions at a particular point. He succeeds in controlling and reducing his anxieties until they refer only to an inanimate object symbolising the lost or unsatisfactory infantile love object. His sadism is therefore less archaic and his anxiety proportionately less than in cases of paranoia. The same can be said of the relation of drug addiction to melancholia. The internalised anxieties seen in the depressive are, in the case of the depressed drug-addict, much contracted. And the element of hysteria present in such cases finds an outlet in the physical disorders consequent on the addiction. The drug is thus a substance with sadistic (injurious) properties which can exist both in the outer world and within the body, but which exercises its sadistic attributes only when incorporated. It is this situation which represents a transition between, on the one hand, the menacing externalised sadism of a paranoid system or the actual internalised sadism of a melancholic system and on the other hand, the less threatening condition that is represented by the ambivalence of the obsessional neurotic or hysteric to his instinctual objects.

Finally the close connection between drug-addiction and both inhibitions and perversions of sexual function justifies the view that drug-habits occupy an intermediate position between autoplasic disorders (psychoses and neuroses) and alloplastic disorders (sexual and social abnormalities). Drug addiction is as much a 'social' abnormality as an 'individual' disorder.

## Chapter XIV

## PSYCHOSEXUAL DISORDERS

In the days before the existence of the unconscious mind was recognised and when in consequence the part played by infantile sexuality in neurogenesis was not realised, it seemed natural to regard sexual difficulties as essentially constitutional in nature, traceable in the last resort to physiological disturbances of function. Despite the discoveries made by Freud, this outworn tradition still lingers and is reflected in numerous forms of organic treatment, e.g., by hormones, sedatives, stimulants and other pharmaceutical devices. Proper appreciation of the significance of sexual disorder depends on recognition of the following facts (1) that the sexual instincts pass through elaborate phases of development in infancy (2) that these infantile instincts give rise to acute unconscious conflict, which, already in early childhood, can be expressed either directly in the form of inhibition and perversion of sexual life or indirectly in the form of neurotic symptom-formations, (3) that instinctual manifestations cannot be accurately assessed unless the part they play in the total mental function of the individual is taken into account.

All this can be summed up in the generalisation that psycho-sexual difficulties are not simply disturbances of the sexual instincts: *they are essentially inhibitions or modifications of instinct the unconscious aim of which is to reduce mental conflict*. Nevertheless more often than not they cause both physical and mental 'pain', even increase the very conflict they are intended to lessen. In other words they are *systems* of mental and physical reaction, which, like psycho-neuroses, psychoses and other symptom-formations have *protective functions* to perform.

Experience in estimating the gravity of sexual difficulties can be acquired only by making a practice of submitting all cases to a thorough psychological examination, subsequently correlating, first, the amount of sexual disturbance with any minor or major symptom-formations that may be present and, second, the degree of sexual difficulty and of symptom-formation with the total function of the personality. This in turn involves a close investigation of any character peculiarities that may be present. In a sense therefore there is no such thing as a specialist in psycho-sexual disorder; or, more accurately, the specialist in psycho-sexual disorder must be a psychological specialist who is at the same time familiar with psycho-analytical discoveries as to the nature of sexuality.

Many interesting correlations can be established by adopting this

approach. For example, quite grave sexual perversions can be found in persons shewing practically no symptom-formations, certainly no neurotic or psychotic symptoms. So much so that some authorities are ready to grade uncomplicated sexual perversions as a form of psychopathy (q.v.). Again, although this is less common, some extensive neurotic formations are apparently compatible with normal sexual function. In actual practice, however, combinations of symptom-formations and some degree of sexual dysfunction are by far the most common. Correlations with social capacity vary. In some cases sexual difficulty and interference with social capacity run in direct ratio. Impotence and incapacity to work are frequently associated. In other cases, however, inhibition of sexual capacity runs in inverse ratio to working capacity which is apparently exaggerated for purposes of compensation. This is most common in middle-age. Similarly the amount of inferiority experienced varies: it may be so intense as to affect the whole tempo of the individual's life, or it may be concealed by a compensatory grandiosity. The touchiness and at the same time the aggressive bumptiousness of the small impotent man are proverbial.

When making final assessments of the gravity of sexual difficulties the clinical psychologist must keep his standards elastic and must allow for individual variations. The reason for this is that no very dependable norms of sexual function have yet been established. The vast majority of sexual abnormalities are never examined because the individuals in question readily come to terms with these, their favourite peculiarities. Cases that come to consultation have either experienced some variety of disability, e.g., mental pain (inferiority feeling) or social incapacity (undue shyness and reserve) or in some cases conscious moral conflict. Sometimes all three are present. The prognosis in such instances is much better than in cases where sexual difficulties are *discovered* in course of examination.

The fact that sexual inhibitions can cause mental suffering and sexual perversions also some degree of moral conflict suggests that, as in the case of symptom-formations, sexual disabilities are influenced to some extent by unconscious mechanisms of self-punishment. Indeed it is interesting to compare sexual disability or perversion with neurotic symptoms to see how much they have in common and in what respects they differ. One important difference between neuroses and perversions is that in symptom-formation the true sources of conflict, viz. infantile sexuality and infantile rivalry, are disguised; whereas in the sexual disorders, certainly in the perversions, the infantile nature of the sexual difficulty can scarcely be disguised. Perversions openly indicate their infantile antecedents. This 'admission' on the part of the patient is however qualified in an ingenious way. Attention is deflected from more important unconscious factors, e.g., the wish for incestuous



intercourse, by stressing in consciousness a particular non-genital element. In this way the importance of heterosexual genital intercourse is denied. Moreover, except in cases of sadistic and masochistic perversions, there is no hint that unconscious rivalry, hate and aggression are important factors. Perversions also allow a degree of pleasure which is accepted by the ego: in this respect they differ from neurotic formations which are not only painful but rejected by the ego.

The most convenient way of classifying sexual difficulties is to distinguish: (a) inhibitions: (b) perversions and (c) marital difficulties and incapacities which may or may not be associated with some degree of inhibition or perversion. Some observers choose to consider masturbatory difficulties, e.g., compulsive masturbation or masturbation associated with perverse phantasies, in a group by themselves. This will seldom be found necessary, since masturbation is but one of the manifestations of sexual activity and must be therefore correlated with other sexual expressions, either conscious or unconscious. Detailed examination of these three main groups shews that each is capable of sub-division in terms of depth, chronicity and stages of infantile development concerned. It seems probable that in course of time a parallel series will be established, on the one hand of psycho-neuroses and psychoses and on the other of sexual inhibitions and perversions having a similar etiological basis and on the whole similar prognosis.

### 1. SEXUAL INHIBITIONS

The striking feature of sexual inhibitions is their economy of function. *They protect against unconscious anxieties and guilts without the expenditure of psychic effort necessary for symptom-formation.* Whereas the symptom-formation depends on maintaining an elaborate system of compromises between unconscious instincts and ego-institutions, inhibitions do away with the necessity for compromise and call for activity on the part of the ego only. Inhibitions can affect (a) sexual interest and curiosity, (b) the degree and quality of sexual satisfaction or (c) the actual technique of sexual activities. Inhibition of interest if persistent is extremely significant, it may indeed be a sign of serious maladjustment. But it is rarely regarded as such by the patient himself. Characteristic disturbances of the degree and quality of sexual feeling can be observed in women suffering from *frigidity*. This varies from absence of capacity for orgasm to complete absence of erotic feeling in intercourse (anaesthesia). In the latter case coitus is frequently associated with some degree of pain (dyspareunia) or spasm (vaginismus) and may give rise to a phobia of intercourse. Interference with the technique of sexual activities is more obvious in the male. Minor difficulties are manifested by *inhibition or omission of various forms of*

*fore-pleasure* through which normally a number of infantile forms of sexuality are gratified in a way consonant with adult sexual codes. Mild *impotence*, i.e., difficulty in erection, penetration, sometimes in achieving ejaculation is one of the commonest forms of psychological disturbance. Some degree of *ejaculatio praecox* (or precocious emission) is also common. These varieties of inhibition are the most obvious of all psycho-sexual abnormalities and, in the sense of unconscious protection from anxieties, the most effective. The frigidity of the woman although corresponding to male impotence rarely interferes with the sexual act.

The significance of these inhibitions varies with their depth and with the amount of unconscious anxiety they conceal. Many of them have the same protective functions as mild conversions or anxiety hysterias. They defend against infantile genital (incestuous) anxieties, i.e., unconscious fear of castration in the male, unconscious conviction of castration and fear of parental seduction and penetration in the female. The underlying disposition in both cases is mildly homosexual. Unconscious (infantile) love drives are charged with sadistic pregenital components (urethral and anal). When these components are overcharged or when the unconscious homosexual interest is overactive, the forms of sexual inhibition are more obvious and more intractable. They then correspond more to obsessional than to hysterical defences. The inhibition is proportionate to the unconscious compulsive and sadistic love attitudes. Some of the deepest and most intractable inhibitions function as substitutes for psychotic defences. They may be part of a depressive guilt system, e.g., a denial of body function based on an animistic conception of the essential 'evil' of the genital organs. Projection anxieties can also give rise to sexual inhibition, but, as a rule, in paranoid and schizoid types, inhibitions are more selective (apparently capricious) and alternate with periods of sexual perversion.

As has been pointed out there are a number of inhibitions of sexual interest, pleasure and activity affecting the different components of *fore-pleasure* in coitus, which may cause serious disturbance of sexual rhythm and of satisfaction in intercourse. The function of *fore-pleasure* is to mobilise genito-sexual energy and under normal circumstances should lead to effective and pleasurable intercourse. These inhibitions are often a source of difficulty in general marital relations. Absence of fusion between erotic drives and attitudes of love and affection is also a stumbling block to the happiness of any enduring relation. Differential diagnosis is not easy unless other symptoms are present by which the severity of the inhibition can be judged. A similar comment applies to these inhibitory practices by which some persons seek to regulate coitus. All sorts of mental and physical disabilities have been attributed to the habits of *coitus reservatus* and *coitus interruptus*. And although

in certain cases the existence of detrimental effects can be established there is no doubt that partly through prejudice, the dangers of such practices have been grossly exaggerated. It will be found that where symptoms follow, there are other pathogenic factors present which determine their form.

## 2. SEXUAL PERVERSIONS

It is a long established Freudian view that although a neurosis is the negative of a perversion they share some protective functions. Whereas in sexual inhibitions any or all of the components of sexuality may be diminished, in perversion one or more components are exaggerated at the expense of normal genital function. Psychologically regarded this constitutes a denial of genital function. The degree of genital denial varies. The pervert for example may have no contact whatsoever with sexual objects, contenting himself with masturbatory practices, which are accompanied by perverted phantasies, for example of being beaten or sexually humiliated. In some cases the phantasy may be acted out. The individual may tie himself up in order to achieve orgasm; indeed fatal consequences have been known to ensue from the practice, a fact which throws some light on the unconscious guilt factors present. Where the perverted impulse calls for the presence and collusion of an external object, orgasm is attained as a rule through satisfaction of the perverted system. In many instances, however, gratification of the perverted sexual aim is followed by normal coitus which however does not arouse the same intensity of gratification. Many married perverts arrive at marital compromises whereby perverted and normal relations are carried out alternately.

Although an immense variety of perversions exists they are capable of classification in accordance with (a) the infantile instincts that are mainly gratified; (b) the erotogenic zones involved (c) the sex of both subject and object, (d) the aim of the impulse and in particular the activity or passivity of the subject and object (e) the unconscious defences exploited, (f) the influence of unconscious symbolism, (g) the dramatic setting of the sexual scene. Naturally more than one of these factors may be present.

The most characteristic forms of perversion are determined by the infantile components of sexuality and the erotogenic zones involved. Thus oral, anal, skin and genital perversions are easy to recognise, for example, in sucking the penis or female genitalia, in anal intercourse or masturbation and in breast and buttock manipulations. The sensory systems involved lend further distinguishing characteristics, visual, olfactory, gustatory, tactile and auditory. Visual, tactile and auditory

forms are commonly combined in the interests of perverted sexual curiosity. Aberration in the choice of sexual object is obvious in the various forms of homosexuality and transvestitism, while displacement from human to animal objects is observed in the different types of bestiality. Further displacement from animate to inanimate objects is a feature of fetishism, where different articles of clothing are the object of sexual interest or activity. The importance of activity or passivity of aim is manifest in various types of homosexuality, and in so-called 'couples' such as the exhibitionism-viewing (scopophilic) couple and the sado-masochistic couple.

The determining force of unconscious mechanisms is best illustrated in the influence of displacement. Displacement is of course a normal activity of the unconscious mind but like all unconscious mechanisms it can be exploited for purposes of defence. Displacement of genital interests to the upper and lower parts of the body is essentially a form of denial. It is most readily effected when the displacement is from the genital to some other erotogenic zone e.g., oral or anal zones. But it can affect more or less neutral zones, particularly if these should be adapted to the purposes of unconscious symbolism. Foot-fetishism for example, owes much of its strength to a displacement 'from above downwards' also to the fact that the heels, toes and feet function as phallic symbols. Armpit perversions illustrate similar tendencies.

Finally there are a number of perversions in which the maximal excitement (always a significant indication) is produced by the dramatisation of specific phantasies. An unusual example which nevertheless illustrates clearly the factor of unconscious phantasy is that where the pervert knocks at the door of a stranger, and seeking entrance on some preposterous excuse, succeeds in having the door slammed in his face, when he experiences orgasm. Dramatising marital intercourse as if it were part of a brothel scene is common. Complicated exhibitionistic and viewing scenes are often arranged in which for example a woman is made to watch her lover make sexual advances to another woman (with or without the presence of a second man), on the completion of which either normal or perverted intercourse is carried out by the principals. Modified forms of *orgy a trois* are represented by having normal intercourse with the sexual object immediately after a visit to a prostitute with whom perverted gratification is obtained.

Sadistic and masochistic perversions occupy a special position in the list of sexual disorders. In one respect they resemble the other perversions, namely, that they are derived from infantile sexual components. A certain amount of fusion of aggression with libidinal impulses is a prerequisite of successful biological sexual function; in addition to which fusions of aggression with sexual instincts occur at all stages of infantile development and are expressed in active (sadistic)

or passive (masochistic) forms. Hence the terms oral, anal, genital, cutaneous sadism and masochism. Regression to these infantile components prepares the way for adult forms of perversion. Apart from this, sadism and masochism are well adapted to the discharge of infantile rivalry and hatred. This brings us to the further generalisation that *the conflict giving rise to perversions is not exclusively sexual*. Surprising as it may seem they serve to conceal unconscious anxieties concerning the aggressive reactions stimulated either by the frustration of infantile sexuality or by the rivalry and hatred aroused by the child's incestuous drives. The varieties of sadism and masochism can be classified in the usual way. Either they involve a directly sexual form of violence or a non-sexual form of aggression ends in sexual excitement and orgasm, or again, a preliminary phase of sexual or non-sexual violence is followed by not very satisfactory attempts at normal intercourse. As has been indicated some forms are associated with the function of particular erotogenic zones., e.g. biting or anal laceration. The commonest varieties involve the cutaneous zones. Active and passive forms of flagellation are frequent, but every possible combination is to be found. In most instances the technique is influenced by symbolic factors. The phallic significance of the beating instrument employed (stick, cane, whip, brush, etc.) is not hard to establish. Wrestling perversions are not uncommon, and indicate clearly the part played by unconscious rivalry and infantile theories of 'sadistic intercourse'. Some forms of tying develop into either sadistic or masochistic practices. An interesting group is constituted by these forms of slashing, cutting, defacing or soiling in which no conscious sexual gratification is experienced or sought. All of which suggests that the relation between sexual and social violence is much closer than is ordinarily suspected.

Finally it should be noted that perversions are not just unmodified infantile remainders due to arrested sexual development or to constitutional factors. Like neuroses they are the result of a psychic *regression*. Adult genital sexuality is sacrificed because of active incest wishes that have remained in a state of faulty repression. The infantile (perverse) component singled out has the function of covering and gratifying (by proxy, as it were) the full incestuous demands of the unconscious.

For a number of reasons psycho-analytical understanding of perversions is rather uneven. Naturally the frequency of certain forms of perversion has led to a concentration of energy on these to the comparative neglect of rarer forms. Homosexuality and exhibitionism, for example, constitute the largest proportion of sexual offences, and interestingly enough are the perversions that appear most frequently in the consulting room. Incidentally the type of case that appears in court differs in many respects from that coming to consultation. The former

may be sent for treatment under a probation order but is more difficult to treat than cases impelled to seek advice by their sense of guilt or inferiority. It is convenient, therefore, to outline in the first instance the mechanisms that determine the various forms of homosexuality.

*Homosexuality.* This is by far the most advanced and organised form of sexual perversion. In many cases apart from the denial of heterosexual genital and reproductive function, the manifestations of homosexual love-feeling and the attitude to the love object cannot be distinguished from those associated with normal heterosexual love. So much so that many descriptive psychologists regard it as a normal form of sexuality arising from constitutional pre-disposition. For the same reason they regard with disapproval or scepticism any attempt to treat homosexuality along psychological lines. The distinction between constitutional and endopsychic factors in homosexuality can be effected satisfactorily only on the basis of psycho-analytical examination. It soon becomes evident that whatever the constitutional factors and however elaborate and sophisticated the love-manifestations, homosexuality represents a regression to an earlier stage of sexual development. It is in many respects closer to pure narcissism than any other form of object-choice. Indeed it is often described as lying half-way between narcissism and normal object-choice.

So far, only a few of the main types have been exhaustively studied and classified. *Like neuroses and psychoses the forms vary in accordance with infantile fixation.* Some simple types of male homosexuality are the following. The love-object chosen is essentially a substitute for the self and is loved as the subject wished to be loved in the first instance by his mother and later by his father. So-called 'active' homosexuals frequently conform to this pattern. In 'passive' types on the other hand, the subject endeavours to satisfy his needs in the main by an identification with the mother imago. At the same time he ousts and revenges himself on the mother. His purpose now is to be loved by and submit to the father. In both active and passive types the form of sexual technique adopted depends on the infantile components that were accentuated during the infantile period of family attachment. Oral intercourse, masturbation and anal (or intercrural) intercourse are common. Particularly in oral forms there are, however, still remainders of the former wish for a passive relation to a good mother (breast). In all cases the original ambivalence to the mother is a fundamental factor, and according to the depth of this reaction a variety of different fears of women are developed, the commonest being a conscious horror of the female genitals with unconscious fear of castration. A third common type is where incestuous drives have been displaced from mother to sister. This accentuates the factor of rivalry with the brother. The homo-

sexual love object is then a substitute for the brother. Hatred and rivalry are denied and a mixed active-passive relation is substituted, frequently expressed through mutual masturbation.

The psychic situation in female homosexuals is more complex. It is true that a number of types exist which, allowing for an appropriate alteration in gender, bear close resemblances to those described above. Homosexual attachments concealing an earlier sister rivalry, for example, are extremely common. In all cases, however, there are two complicating factors to be taken into account; first, that the female passes through her negative (mother) attachment *before* reaching the positive (father) Oedipus conflict (not *after*, as in the case of the boy), and, second, that her castration anxiety links up with deeper phantasies of body-mutilation than in the case of the male. She believes that she has already suffered castration and that she is bound to suffer still further injury. Penis dread is reinforced by earlier breast dread which in its turn was provoked by oral hate of the breast. Moreover, the girl has had stronger sadistic reactions against the mother's inside (babies and reproductive organs). All this combines to increase anxiety lest her own internal organs should be damaged or destroyed. This anxiety is denied, in active types, by simultaneous identification with the mother and with the more active partner. A great deal of hostility and rivalry between men and women is based on these unconscious factors.

*Other Forms of Perversion.* In course of time it will no doubt be possible to establish a detailed etiology for each variety of perversion. So far however only the most outstanding variations in perversion formation can be accounted for. On the whole serial differentiation according to developmental fixation is the most useful approach. Thus it is usually possible to identify two main subdivisions of each group; (1) those in which, despite the severity of the clinical manifestation, the unconscious anxieties belong to a comparatively late infantile fixation usually about the age of 3 to 5, i.e. roughly comparable to hysterical fixations; (2) those in which, even if the manifestations are comparatively mild, the anxiety is of a deep type. In the latter instance there are usually other indications present to help in diagnosis, e.g., the association of fetishism with alcoholism suggests that the perversion is a deep one involving some psychotic or pre-psychotic mechanisms. In *fetishism* the processes of denial (repression) and displacement of incest wishes are more accentuated than in homosexuality. Sexual interest is diverted from the body to articles of clothing. The choice of fetish is influenced by two main considerations, the sex of the person with whom the clothing is associated, and the unconscious (usually symbolic) significance of the fetish itself. Thus we can distinguish heterosexual, homosexual and bisexual types of fetishism, involving sexual interest in hats, shoes,

gloves, stockings, underclothing, corsets, belts or bags. The nature of the fetish is easier to determine when it is associated with some degree of sexual intimacy with a real sexual object. But in many cases the fetishistic object is used as a masturbatory stimulus only. Collections of fetishes are often made and provide occasion for polyfetishistic orgies. In some cases waterproof garments or even pieces of waterproof or blanket are used. In short there is almost no end to the exploitation of the unconscious mechanism of displacement. It is clear however that non-genital erotogenic zones influence the process of displacement by exercising a 'pull' on genital libido. The mackintosh fetishes in particular can be traced also to pre-genital fixations of an anal and urethral type. Displacement is further influenced by anxieties arising during early stages of reality development. During infancy anxieties concerning food are usually followed by anxieties regarding clothing and no doubt the libidinisation of clothing originally represents an attempt to overcome these primitive almost persecutory fears. Regarded from this point of view the fetish is seen to be the negative of a contamination phobia.

Next to displacement, the factor of symbolism plays the most important part in determining the nature of the fetish. As has been suggested fetishes are commonly bi-sexual, symbolising both male and female genitalia. Pre-genital symbolism is also operative. Yet it is a well-established fact that the phallic symbolism of the fetish is the most significant element in the fetish. This gives a clue to the main etiological factor, namely an infantile obsession with the genitalia combined with a horror of genital mutilation. This is stimulated by a particular type of infantile unconscious phantasy, viz., that the female (mother's) genitalia include a penis or that the father's penis exists within her body. This phantasy is universal but gathers unusual strength in individuals of an unconscious homosexual disposition.

Displacement of sexual interest from body to clothes is also observed in *transvestitism*. The narcissistic and homosexual elements are more obvious here. By dressing himself and usually masturbating in female clothing the male transvestitist dramatises himself as a 'woman (symbolised by clothes), with a (real) penis'. By so doing he gratifies his unconscious homosexuality but denies his castration fears. For corresponding reasons the female transvestitist represents herself as a '(real) woman possessing a penis (symbolised by male clothing)'. In both fetishism and transvestitism pregenital (anal and urethral) sexuality is emphasised, and in both cases there is regressive denial of genital Oedipus wishes.

*Exhibitionism* and *viewing* perversions are defences against similar incestuous anxieties, but the element of denial although in some respects more emphatic allows more outlet to unconscious phantasy. Obviously



the main infantile feature is the regressive gratification of infantile sexual display and curiosity respectively. On the other hand sexual relations with objects are materially restricted; physical contact is denied and the cycle is usually brought to end by spontaneous orgasm or by masturbation. Subdivision of these perversions can be effected in accordance with the sex of the object involved, and with the setting of the act. Many of these settings clearly indicate the infantile situations with which the infantile impulses were originally associated. Although most forms of exhibitionism and viewing are concerned with the genital organs, buttocks or breasts, in some cases the interest extends to the body as a whole. This displacement contains an additional element of genital denial and is found chiefly in persons with strong cutaneous erotism who have suffered excessive anxiety of body mutilation in infancy. In certain cases a close association of flagellation interests can be detected, and in others the influence of bisexual promiscuity is decisive; as when the exhibition takes place in view of a number of strangers of both sexes.

The importance of *sadistic perversions* varies. Some of the milder forms correspond with obsessional formations and are only slightly deeper in fixation level. When they are associated with *coprophilic phantasies* or *coprophagic activities* the fixation points may be regarded as deep. Some are simply defences covering phantasies of a paranoid type. Here again confirmatory evidence should be sought in the general character and disposition of the individual. The more serious varieties are usually associated with great emotional instability and attitudes or conduct of an anti-social type and are usually classified as *psychopathic*. Similarly with *masochistic perversions*: some of them are due to simple infantile anxieties of a homosexual type. The unconscious guilt factor is usually more obvious and on the whole these milder types correspond to severe obsessional formations. Others may mask a depressive system. In the latter case excessive infantile oral sadism is a predisposing factor; but in all cases anal, skin and muscle sexuality contribute to the formation in varying degree. As in all other perversions the amount of normal libido present varies, and provides some indication of the relative severity of the condition. Love capacity is in most cases considerably depleted.

### 3. MARITAL DIFFICULTIES

Strictly speaking these are combinations of sexual and social difficulties. The social disorder is however confined to the family circle, to the marital partner, children and relations. Many people succeed in avoiding a psycho-neuroses in middle life by making an unhappy marriage or by allowing a previously satisfactory relation to come to

grief. These are essentially abnormalities *a deux*. Both parties are in an emotionally unbalanced state. Indeed, to begin with, this very factor appears to arouse a certain fascination leading to impulsive marriage. Obviously it is possible to classify marital disorders in a great number of ways. Practically every stage of infantile development can contribute either to the success or to the failure of marriage. Thus the development of infantile sexual instincts, the relationship to parents or to brothers and sisters, and the degree to which character has been influenced by early introjections and identifications are responsible for characteristic difficulties. And there are innumerable combinations of these factors each of which produces a more or less characteristic marital situation. For practical purposes however they can be grouped in one of the following ways: (a) disorders consequent on manifest sexual maladjustment; (b) disorders due to unconscious factors. The latter can then be sub-divided in a variety of ways of which the most important are:—disorders consequent on faulty object-choice and difficulties due to unconscious homosexual organisation or to unconscious sexual antagonism.

It is scarcely necessary to catalogue the manifest sexual maladjustments that give rise to marital difficulty. Either inhibition or perversion of sexual function may lead to the break-up of a marriage, partly because of the difficulty experienced by the inhibited or perverted individual in adjusting to normal married life and partly because of the effect of his or her psycho-sexual system on the marriage partner. The commonest cause of difficulty is that due to impotence or frigidity. In such cases the gravity of the situation can be roughly measured by the severity of the inhibition. Mild psycho-sexual difficulties are not hard to resolve and marital problems arising from them are likely to disappear once the precipitating cause has been dealt with.

Marital disorders due to unconscious causes usually manifest themselves in the first instance in difficulties of domestic adjustment, but sooner or later they affect manifest psycho-sexual relations and so lead to the formation of a vicious spiral. Types vary greatly in detail but shew many features in common. On the husband's side there may be a difficulty in attaining an adult male attitude to women, behind which lies a passive feminine disposition. These men are usually mother-fixated, but the attitude to the mother imago is nevertheless strongly ambivalent. Potency varies considerably. Some are potent but get no pleasure in intercourse, others have uncertain potency combined with promiscuous and rather compulsive sexual drives. Others again are very weakly potent, irregular and infrequent in intercourse. In such instances the sexual and social techniques of marriage usually include a habit of disappointing the woman, or alternatively of inciting the woman to attack (nag) the man.

The reactions of wives also vary. They have frequently a strong homosexual fixation with unconscious hostility to the male organ covering an equally strong ambivalent attitude to the father. Such cases are usually rather frigid. The frigidity combines hostility to the father with an expression of hatred to the mother-imago whose genital functions are denied. In other instances there is no frigidity but a concealed (hysterical) fear of penis function, particularly of penetration. In the former type the husband is treated as an inferior possession, subjected to criticism and subsequently neglected in favour of children who are nevertheless a constant source of anxiety.

The reciprocal relations of husband and wife are of especial interest. The following are common instances. An obedient, passive type of man who is nevertheless potent marries a woman whose temperament is aggressively homosexual and who becomes increasingly dominating and possessive. He becomes more and more cowed but succeeds in discharging unobtrusively, an increasing amount of hostility to his wife. In extreme cases this becomes openly explosive and ends in strained relations or complete rupture. Again, women of a masochistic hysterical type may marry rather impotent and narcissistic men. They dread coitus and protect themselves against it, e.g. with vaginismus. The husband inclines to become increasingly cruel on a psychic level. Once such a woman has overcome her difficulties she tends to welcome love-making, at which stage her husband's inhibitions become a source of trouble. He is made to feel inadequate and she becomes increasingly discontented. Or, again, the Don Juan type marries a slightly frigid and unconsciously (active) homosexual woman. The marriage remains successful until children are born, when simultaneously the man turns from the woman and the woman turns to the male children. Many of these cases are incurable.

In yet another group of marital disorders, the marriage is jeopardised by gross disturbances of mental function on one or other side. The classical case is that of delusional jealousy, where one partner accuses the other of repeated infidelity. Trivial incidents are magnified into grotesque disproportion and made the basis of sexual suspicion and reproach. Gradually both parties are reduced to a state of misery which can only be brought to an end by dissolution of the marriage. Interestingly enough only a minority of such situations end in actual dissolution, a fact which throws some light on the psycho-sexual constitution of both parties. As might be inferred from the paranoid type of reaction exhibited, the jealousy is due to unconscious homosexual difficulties. Pathologically jealous women whose own disposition is active and dominating in type frequently marry men with unconscious feminine trends, whose passive disposition enables them to endure the aggressive suspicions to which they are constantly subjected. In less

pronounced cases it is sometimes difficult to arrive at an accurate assessment of the situation, more particularly when the accused partner has before marriage endeavoured to offset his unconscious passive trends by promiscuous behaviour. In such cases the wife may react to his pre-marital infidelities as if they had occurred during the marriage.

From the prognostic point of view, the severity of marital disorders can be gauged by the developmental level at which the disturbing factors develop. Unfortunately no exact information is available as to the incidence of these difficulties amongst so-called normal people, or, more accurately, amongst those who do not come to consultation. But although prognosis should always be guarded, it is desirable in the first instance to adopt a conservative policy. As has been suggested, the fact that a marriage is disordered does not imply that it will necessarily end in dissolution. Even in cases of complete impotence, the psychic relation of the couple may be strong enough to maintain an uneasy and nervous equilibrium. The main obstacle to successful intervention is that whereas as a rule both parties require analytical treatment it is rare to find both ready to accept this view. Moreover, the unconscious gain from an unhappy marriage is difficult to eliminate.

In this survey of psycho-sexual disorders only those conditions have been considered which are likely to be met with in everyday practice. It is desirable, however, to have some understanding of psycho-sexual manifestations which are rarely met with in the consulting-room. In the nature of things it is unlikely that an adult prostitute will voluntarily seek advice on her condition; although nowadays it is not uncommon for adolescent girls who appear to be 'larval' prostitutes to be sent for treatment by Juvenile Courts. But such cases as have been analysed indicate clearly the importance of irregular sexual upbringing, of unconscious homosexuality and anal erotism and of unconscious sexual antagonism. Nevertheless the belief that *prostitution* is a 'natural' phenomenon due mostly to economic factors dies hard. Mental measurements of these types show clearly that the mental level of the prostitute is a low one, frequently bordering on deficiency.

But although prostitution is mostly regarded from a social angle, a *compulsive interest in prostitutes* is a well recognised pathological state. A by no means inconsiderable number of marriages are ruined by this obsessional type of sexual interest. The husband for example, may find that he is impotent with his wife but capable of an aggressive potency with prostitutes. In such cases it is easy to observe that the dichotomy of erotic and idealistic elements of sexuality which is a normal feature of infantile sexuality has not been overcome at puberty. Taken early enough the condition is usually amenable to analytical treatment.

## Chapter XV

## SOCIAL DIFFICULTIES

The mere fact that it is necessary to describe a group of psycho-pathological conditions as 'social' disorders gives some idea of the difficulties encountered in effecting psychiatric classifications. In the case of physical disease it is convenient to classify clinical conditions either in accordance with the organ or body system affected, or in terms of the pathogenic agent. And up to a point this custom is followed also in psychoanalytical medicine: psycho-pathological states can be and often are classified in structural terms, e.g. in accordance with the level of psychic structure affected (narcissistic neuroses) or even in accordance with the mental organ or institution involved (guilt-neuroses). But except in the case of 'infectious diseases' it does not occur to the physician to classify organic disease in terms of its *effect on environment*. Although irritability is traditionally associated with disturbances of the liver, diseases of the liver are not nowadays classified under the heading of 'irritability and quarrelsomeness at breakfast'.

In psychological medicine the situation is otherwise. It is true that certain mental institutions are developed for the specific purpose of regulating the social contacts of the individual; and it is therefore quite legitimate to speak of disorders of these institutions; as, for example, when one describes hypertrophy or atrophy of the super-ego as a social disorder. But this is not the only factor responsible for the use of the label 'social disorder'. As the term 'delinquency' or 'delinquent state', or, for the matter of that, the term 'tantrum' clearly indicates there are certain social reactions which are singled out for diagnostic attention because, whether or not the individual exhibiting them regards them as normal, they are yet stigmatised by society or by the family as criminal or disordered. In other words, the factor of environmental reaction determines to some extent the isolation of a special group of mental disorders.

In view of the confusion and overlapping caused by the use of this social criterion, it is desirable to preface the description of social disorders by an outline of different standards of classification. Generally speaking psycho-analytical classifications are regulated by metapsychological considerations. In particular structural and dynamic criteria are adopted to distinguish different disorders. Symptom-formation, for example, is a structural term and symptom-formations are further classified in accordance with their relation to the ego. Although the ego itself is not affected by the diseased process, the symptom-formation

may in one case penetrate the structure of the ego and in another be isolated from or encapsulated by the ego. A hysterical phobia is more likely to operate in isolation than an obsessional ritual which may penetrate deeply into or succeed in compressing the normal ego.

Again the term 'character disorder' is a structural caption implying that the structure of the ego itself is the locus of disorder. Sexual disorders on the other hand are mostly classified in dynamic terms namely, in accordance with the source, aim or object of the instinctual energy concerned. Here we encounter one of the most obvious examples of confusion in classification. Exhibitionism and homosexuality are the commonest forms of sexual delinquency and therefore can be included amongst social disorders. Yet it would be absurd to consider them under any heading other than that of psycho-sexual disorder.

It follows that in isolating social disorders, we must have regard to the determining factor in diagnosis; whether, for example, the disordered functions of the ego are regarded as the most important element in the case, and the effect on social relations as secondary as (e.g. in obsessional and depressive character formations); or whether the effect on social relations is the primary criterion and the disorder of the ego is relegated to second place, (e.g., in anti-social characters). By this definition, of course, even transitional states such as alcoholism and drug addictions can be regarded as social disorders. These states are certainly due to ego-disorder as well as to sexual maldevelopment. Yet they have a marked effect on social relations, and are at times regarded by society as anti-social disorders, are indeed often treated as if they were delinquent states. From the point of view of etiology and developmental fixation, however, more would be lost than gained by including them in the category of social disorders.

We are therefore reduced to a general definition of the term as follows: *a social disorder is one in which the capacity of the individual for harmonious adaptation to the various social settings in which he may find himself is, whether the individual is aware of it or not, interfered with either to the point at which his total mental function is prejudiced or to the point at which society is prepared to react to his behaviour with social or penal sanctions.* Disturbances of harmonious adaptation to social conditions can then be sub-divided according to whether (a) ego-structure is affected as, e.g., in diseases of the super-ego, (b) the instincts are disordered, as, in sexual perversions, (c) the economic function of the mind is disturbed, as when the exaggerated use of the unconscious mechanism of projection leads to a persistently hostile reaction in social contacts.

Having accepted this provisional definition we can proceed to eliminate those social difficulties which are more satisfactorily dealt with under other headings. These include social difficulties arising directly

from (a) psycho-neurotic symptoms, e.g. hysterical crises or obsessional inhibitions (b) disturbance of reality-proving, as, e.g. in the various psychoses (c) drug habits and addictions (d) psycho-sexual deviations and marital difficulties. We are then left with certain well-defined groups in which disturbance of social adaption is not only the main symptom but the main personal problem. There are five such groups; (a) social inhibitions, (b) character peculiarities, (c) mixed types combining characteristics of (a) and (b); (d) delinquent types (e) cases of psychopathy or social perversion. Of these groups the first three are isolated on purely endopsychic considerations; the isolation of the fourth and fifth groups is to a varying extent influenced by social considerations.

Before considering these groups in detail it should be emphasised that from structural and functional as well as from dynamic points of view there is a close resemblance and relation between abnormalities of social reaction and sexual difficulties. In both cases unconscious conflict over infantile sexuality or aggression is denied, and in both cases the abnormalities are to a considerable extent accepted by the ego. But whereas in the case of sexual disorder a *sexual* factor is openly inhibited or exaggerated in order to conceal unconscious conflict, in the case of social disorders unconscious conflict over infantile sexuality and aggression is denied by displacement to *non-sexual* activities. The inhibitions or perversions affect *personal character* and *social relations* to objects. The displacement is of course purely unconscious although it is interesting to note that concentration on work or on various social activities is often recommended as a 'cure' for sexual difficulties. The fact that the ego tends to accept them, differentiates both social and sexual difficulties from psycho-neurotic symptoms in which the disguised results of conflict are dissociated from and rejected by the reality ego. This acceptance also explains why social dysfunctions are more difficult to treat than the corresponding neurotic or psychotic symptoms.

### 1. SOCIAL INHIBITIONS.

These can be sub-divided into inhibitions affecting mainly the *capacities* of the individual (e.g. lack of concentration or of working and learning capacity), and those affecting his social relationships e.g. shyness, blushing, inferiority feeling. But this is a rather arbitrary division. There is always a good deal of overlapping between the sub-groups. Many social inhibitions correspond closely to mild anxiety or conversion hysterias. Thus social shyness may be the equivalent of an erotophobia (i.e. fear of blushing), of a functional eczema or erythema, or of smell and contamination phobias. Undue shyness is a compound of unconscious anxiety, guilt and aversion, diffusely expressed through

personality reactions instead of being localised in the form of a phobia. It is sometimes difficult to distinguish between inhibitions of an anxiety type and those of an obsessional nature. Lack of concentration and inertia may be due to hyper-activity of unconscious phantasy (hysterical type) or it may be due to an over-expenditure of energy intended to hold unconscious sadistic phantasy in check (obsessional type). In obsessional inhibitions there are usually other signs present which help to confirm the diagnosis, e.g. tendency to indecision, undue scrupulosity, sensitiveness to dirt, food faddiness, irritability in situations of social intimacy. Many forms of inertia and lack of concentration are related to a deep inferiority reaction of a depressive nature. Some deep forms of social reserve are due to the existence of a paranoid type of reaction and can be distinguished by the association of hypercritical and negativistic responses. In some cases the effect of extensive inhibition on social adaptation is almost as profound as that of a mild catatonia. In such instances a deep sadistic (guilt) factor can be presumed.

Inhibitions both of capacity and of social contact have, as has been suggested, a close connection with unconscious sexual difficulties. Retardation or inhibition of learning and play are frequently due to faulty repression of conflict over infantile sexual curiosity, the more so when the unconscious sexual theories adopted in childhood are sadistic in type, e.g. involving the conception of sadistic coitus, impregnation and delivery. Two other sexual factors should be noted. Unconscious difficulties over homosexual longings in early childhood may give rise to extensive disturbance of adult social relations, for example, to the excessive diffidence in the company of persons of superior executive status. Again infantile sexual rivalry with the parent of the same sex may be responsible in adult life for undue timidity in relation to superiors.

The specific unconscious components giving rise to the inhibition can frequently be surmised either from its localisation or from the symbolism of the activity inhibited. In types corresponding to hysteria and associated with conflict over infantile genital (incestuous) sexuality, the sexual symbolism is not difficult to translate, e.g. occupational cramps (piano-playing, typing, etc.) due to conflict over the incestuous phantasies associated with infantile masturbation. Activities symbolising coitus (shooting, motoring, driving, climbing ladders or heights) are often affected by this type of (anxiety) inhibition. In inhibition of work there is usually a strong masochistic (self-punishment) element present. By reason of this self-induced lack of working capacity the individual seriously damages his chances of living a normal life; he can for instance easily put himself in a situation where he has a good economic reason for not undertaking marriage. This is a much more



passive manifestation of the masochistic urge than when the individual chooses an occupation detrimental to his interest. Moreover should the lack of earning capacity involve also dependants, an unconscious attitude of revengefulness towards the family may be suspected. Some pseudo-hysterical forms apart, the more widespread the inhibition, the deeper the fixation, and the stronger the unconscious component of sadism the more serious the prognosis.

But these cruder forms do not exhaust the varieties of inhibition. There are some inhibited types presenting an appearance of normality whose daily life is nevertheless a continuous series of inhibited reactions. In such cases even the most trivial social observance, e.g. shaking hands, meeting a stranger, conducting a conversation, walking across an open street, standing under a street lamp are unconsciously interpreted as occasions of danger. The inhibitions in such cases merely represent precautions intended to meet the unconscious (instinctual) danger (repressed wish) symbolised by the social situation. As might be expected many types of inhibition shew a tendency to vary at different periods of life. For this reason adolescent forms need not as a rule give rise to serious misgiving; whereas the development of inhibitions after middle-age is disquieting.

## 2. CHARACTER PECULIARITIES.

As distinct from inhibitions which are on the whole negative manifestations and which may be associated with an otherwise normal character, there are more positive reactions (psychic and behaviouristic patterns) which more often than not produce social frictions or otherwise damage the individual's capacity for adaptation. These are called *disorders of character*, to distinguish them from symptom-formations in which the character of the individual may not be affected qualitatively. The varieties most easy to detect are those in which the mechanisms involved closely correspond to those detected in the psychoneuroses or psychoses. A true *hysterical character* exists although it frequently goes undetected because it is taken to be an exaggeration of normal behaviour. Where it is recognised it is usually wrongly labelled as true hysteria. Hysterical characters are not only over-sanguine and passionate in their social likes and dislikes but in both social and sexual relations are exacting and aggrandising. To those who exist outside the orbit of these likes and dislikes they can, however, exhibit a remarkable indifference and aloofness. They are generally extremely babyish in emotional contact and readily subject to illusions. Partly because of this tendency to illusion formation and partly because of their gift for fabrication, their daily lives appear to be full of extravagant incident which, however, usually ends in frustration and disappoint-

ment. And indeed it appears that they are capable of precipitating emotional responses in others. An element of infantile sado-masochism in their make-up is expressed and denied by a combination of masochistic over-solicitousness and querulous self-sacrifice which usually ends in alienating their social environment. In acute cases the hysterical character tends to dissociate himself temporarily from social contacts and may give a false impression of depersonalisation.

The *obsessional character* groups include such conditons as lack of emotional feeling or response to real emotional situations, incapacity to make up the mind or to act decisively, aimless thinking, superstitiousness, rigid formalism, wasting time on the minutiae of life, miserliness, etc. Such individuals tend to be disappointing to others and frequently get into hot water on that account. They may make good officials but lack enterprise and tend to give way to a masochistic defeatism. Also they do not readily fall in love.

Slightly *paranoid characters* are easy to recognise although they seldom come to consultation. Believing the external world to be at fault, they feel that there is 'nothing the matter' with them. They are above all suspicions, critical and hostile, and these attitudes alone are sufficient to produce a crop of social misfortunes. The clashes that ensue are repetitive and closely resemble each other. Usually they occur with persons of the same sex. Persons having difficulty in sublimating unconscious *homosexual* drives are notoriously 'difficult' to get on with. They are either unduly reserved, or, like paranoid characters, use the mechanism of projection to rid themselves of inner self-depreciation, and in so doing become aggressive and quarrelsome. At first these reactions are associated with a few specific situations but gradually they affect most social contacts.

*Depressive characters* are more inhibited than peculiar in a positive sense. *Manic* types with their sanguine and euphoric activities rarely come under observation unless their conduct ends in 'crashes'. Some of the most intractable character formations belong to a *masochistic* group. Individuals of this type repeatedly manoeuvre themselves into self-injuring situations, e.g. losing their money or their employment, being 'taken in' by strangers and acquaintances or 'let down' by friends who appear to be chosen because of their readiness to 'let' others 'down'. *Schizoid characters* may present every known character peculiarity with the exception of hysterical traits. These peculiarities of conduct are due in the main to two factors, first, that the external world is very thinly invested with libido and second that the individual reacts to it on the basis of symbolic interpretation. This gives rise to an apparent indifference to external opinion and to phases of peculiar conduct, which nevertheless the individual is able to justify to his own satisfaction. Apart from this the *schizoid* character exhibits marked

signs of egocentricity, which is frequently described under the heading *narcissistic character*. The more cultured types have a marked predilection for metaphysical speculations of a fruitless kind. Almost all of them tend to sexual inhibitions or perversions. When marital relations exist these are almost invariably unhappy. The etiological factors responsible for these various types are practically identical with those described for the corresponding neuroses or psychoses. (q.v.).

### 3. MIXED TYPES

By no means all or even a majority of character disorders can be classified under the above headings; nor are all character peculiarities true to type. Various combinations of social inhibition and character peculiarity exist with or without signs of sexual inhibition or perversion. They can be classified in accordance with the type, the mechanisms employed or the depth of conflict. Some of these have already been described (see Marital Difficulties). Many obsessional bachelors and agitated spinsters combine the most remarkable peculiarities of conduct with sexual habits of a mildly perverted order, or alternatively with gross sexual inhibitions. A more intractable group is comprised of individuals who are threatened with the impotency of middle age or who have passed the climacteric. The former exhibit in addition to anxiety symptoms a deterioration of capacity for work and for suitable social contact: the latter combine regressions in personal habits with regressive character changes; they become infantile, peevish and more than a little paranoid in reaction. Nevertheless it would not be accurate to describe these mixed types of character disorder as psychopathic (see below): they are distinguished from psychopathic cases by their variability, the presence of inhibitory mechanisms and the degree of relative adaptability present.

As has been suggested, it would be absurd to represent the foregoing symptomatic types as fully representative of character disorders. They are singled out here because they present themselves from time to time in the consulting room. There are endless varieties of character peculiarity which do not correspond to any particular neurosis: but most of the individuals concerned are not aware of harbouring any particular abnormality and naturally do not feel any necessity to seek advice. The task of classifying systematically these varieties of character disorder has been strangely neglected. It is sufficient to say here that since character is moulded at every stage of development, character changes are capable of classification in accordance with the customary psychological approaches. Naturally the structural approach is the

most convenient, as witness the endless varieties of character that depend on the *structural changes brought about by unconscious mechanisms of introjection and identification*. What is popularly described as 'taking after' the father (or mother) is a superficial manifestation of such character development. And equally obviously it is possible for exaggerated introjections and identifications to cause difficulties in social adaptation. The feminine identifications of the man and the masculine identifications of the woman are no doubt essential to normal social development, but when overemphasised they are frequent causes of friction and ineffective adaptation. Few persons suffering in this way recognise that their conduct is abnormal or capable of treatment. It would be beyond the scope of a general survey to detail the immense variety of character types associated with structural changes. It may however give some idea of their importance to say that a large part of *every* analysis consists in scrutinising the identifications and introjections on which the structure of the individual ego is founded.

Similarly with the dynamic aspects of character-formation. It is not difficult to establish that the main phases of infantile sexuality have a profound influence on character; and psycho-analysts have been at pains to distinguish *oral, anal and genital forms of character-formation*. These formations normally vary in accordance with whether the original impulses have been adequately or inadequately gratified, and whether any conflict they may have aroused has given rise to accentuation or to inhibition of function. Thus, for example, a *gratified oral* type of individual is usually optimistic in attitude, or at least tranquil and self-assured, generous and altruistic. A *frustrated oral type* on the other hand is usually pessimistic in attitude, impatient, irritable, ungenerous and egoistic in a demanding sort of way. Pathological exaggerations of oral character leading to social friction or inadequacy are observed in spendthrifts who exhaust their resources in foolish forms of giving, in misers, in oppressively demanding individuals and a number of other reactive types. Exaggerated oral types are usually envious, jealous and hasty in temper, given to violent crises of emotion. Those however who inhibit their oral reactions may conceal their passive longings with a reaction formation of independence, neither giving nor accepting help.

The main features of the *anal character*, originally described by Freud, are orderliness, parsimony and obstinacy. Such individuals are self-willed, persistent, highly individualistic, and often pedantic. They may tend to parsimony or avarice, shew many reactions of a mildly obsessional type and are rather hypochondriacal in interest. *Urethral character traits* of impatience and ambition may complicate the picture. When strong anal or urethral fixations give rise to conflict, pathological

changes in social conduct are frequently observed. The irritable anal type in particular has difficulty in concealing his sadistic reactions and frequently lands himself in situations of social friction.

*Genital character types* have also been described. The positive (gratified) forms are, however, difficult to specify since satisfactory genital function usually promotes general efficiency in work and social relations. Such types are usually confident and self reliant without being unduly aggressive. Reactive types of genital character are more easy to recognise. They occur in individuals who suffer from unconscious anxieties of castration. Envy and inferiority feeling are common or contrariwise vanity, exaggerated pride and excessive dogmatism. In most cases there is a complicating factor of unconscious homosexual fixation. Probably more than any other libidinal factor unconscious homosexuality is responsible for friction in social relationships.

Naturally many combinations of these character difficulties exist. Exaggerated urethral characteristics are usually superimposed on and aggravate oral character reactions. Oral characteristics are often difficult to distinguish from genital character reactions. In any case it should be remembered that every variety of libidinal character formation may be present in clinically 'normal' individuals. Only exaggerated reactions should be regarded as pathological in type. Here again it is to be noted that although pathological characteristics may interfere seriously with social and individual adaptation, the persons concerned rarely regard themselves as 'abnormal'.

So too with the various divisions of character in terms of *temperamental* reaction, e.g. sanguine, depressed, choleric, changeable, fickle, etc. Pathological variations are easy to detect but are not regarded as disordered by the persons concerned. Only when other and more painful symptoms are present is the sufferer likely to seek advice. In some cases a summation of characterological factors results in a condition of profound self-dissatisfaction. This is a condition which frequently leads to the consulting room. The individual who feels he is 'not making the best of himself' frequently seeks advice, and although he may present few symptom-formations, there are usually present a number of character-disorders which acting in combination are responsible for his condition.

#### 4. DELINQUENCY AND ANTISOCIAL CONDUCT

As has been said earlier, the chief difficulty in classifying delinquent disorders lies in the fact that the diagnostic standards are strongly influenced by codes of civil and criminal law. Nevertheless it can be maintained that *violent or persistent breaking of laws that are generally accepted by the community is in many cases a form of mental disorder.*

Against this view two objections might be raised. It might be maintained that infractions of the multitude of bye-laws and regulations that govern everyday civilian life are not necessarily a sign of abnormality; and there are no doubt many who would protest also that according to this view, the ardent reformer might find himself stigmatised as a delinquent. The medical psychologist is, however, in no way daunted by these arguments. He is not concerned to maintain that cyclists who break lighting-up regulations are delinquents; nor is he immediately concerned with the constitutional status of the reformer, or, for the matter of that, of the revolutionary. His problem is a much more practical one. Amongst the common forms of delinquency are various types of stealing, acts of unreasonable violence and sexual aberrations; and the medical psychologist is able to demonstrate to his own satisfaction that many cases of pilfering, acts of violence and sexual aberrations are amenable to psychological, social and sometimes organic treatment.

At this point the counter-argument is usually advanced that stealing at least is merely the reaction of egocentric individuals to economic hardship; to which the only satisfactory reply is to quote statistics based on a thorough mental and physical investigation of selected types of offender. Such investigations prove that in a great number of cases the causes of delinquency are quite otherwise. The fact is of course that the social labels of delinquency express the natural prejudice and disapproval to say nothing of the self-protective urges of the community, and are therefore unscientific in tendency. *Before we can proceed objectively with a mental investigation of anti-social disorders, the social diagnosis must be transmuted into a diagnosis in terms of individual psychology.* The law, for example, classifies acquisitive crimes in a great number of formal groupings, e.g., pilfering, breaking and entering with intent to steal, burglary, etc., etc. But a moment's consideration will shew that if we adopt a psychological approach these are capable of an entirely different classification in terms of, e.g. the nature of the object stolen, the person or persons from whom it is stolen, the technique of the theft, the nature of disposal (if any) of the stolen property. Thus, stealing can take place in the home, i.e., from parents or relations, or it can affect persons outside the immediate family, shops, railway companies, corporations and so forth. Similarly the nature and disposal of the stolen article varies. All of which indicates that the individual's psychological relation to external 'objects' and to the possession of certain articles must be examined before we attach a final diagnostic label. The key to diagnostic accuracy lies in the discovery of *motive*, and motive cannot be ascertained without a thorough psychological examination.

In the case of sexual aberrations that infringe the laws of decency or

involve prohibited sexual relations, there is no difficulty in establishing that the conditions in question are due to disorder of the sexual impulses traceable in the long run to developmental difficulties in infancy and childhood. These have been considered under the heading of Sexual Perversion (q.v.) rather than of delinquency. It is a significant fact, however, that social delinquency is frequently associated with sexual inhibition and even more frequently with sexual perversion.

Following the same line of approach we can exclude from consideration cases in which permanent deterioration leading to delinquent behaviour is the direct result of organic disease, such, for example, as encephalitis lethargica, cerebral injury or tumour, toxæmias, glandular disorders etc.; provided always these conditions are not complicated by true psychogenic factors. It is of course essential that the existence of organic factors in delinquent states should be ascertained and treated. But these varieties of delinquency do not come within the province of the medical psychologist.

From the psychological point of view there are then four main types of delinquency to be considered; the psycho-neurotic, the psychotic or pre-psychotic states, mentally defective or borderline defective types, and character abnormalities either transient, as in the case of pubertal maladjustment, or persisting, as in the case of psychopathic types. Of these the psycho-neurotic and character groups are statistically the most important. By comparison psychotic and defective types are much less common. Moreover, the latter can readily be detected using the customary techniques of mental measurement.

Strictly speaking the designation *psycho-neurotic delinquency* is a contradiction in terms. For the psycho-neurotic tends more to inhibition of his own capacities than to anti-social conduct. Nevertheless it is convenient to use the term (a) in cases where psycho-neurotic crises result in sporadic outbursts of delinquent behaviour (b) where the unconscious mechanisms discovered correspond to those which usually determine neurotic symptom-formation and (c) where there is a previous history of neurotic crises and/or a number of significant neurotic symptoms are present. No doubt it would be better to classify such cases in terms of the level of fixation or of ego organisation or again of the unconscious mechanisms mainly responsible for the delinquent conduct, but until these levels and mechanisms have been more accurately determined, there is some advantage to be gained by using more descriptive (clinical) terminology.

Episodic '*hysterical*' delinquency leading to crimes of violence is commoner than has been supposed, e.g. strap-slashing, cushion-cutting, ink-slinging, and a number of other offences against property and persons. The peculiar nature of some of these outbursts suggests what is indeed the case, that the choice of object is determined to a large

extent by its unconscious symbolic value. The object damaged is unconsciously equated with significant persons or the organs of significant persons. In the commoner forms of impulsive pilfering, shop-lifting and house-breaking, the factor of unconscious symbolic value also operates but is usually secondary to an unconscious need for revenge as a rule directed at figures who have played a prominent part in bringing up the child, or in the case of adult delinquents of their substitutes. On the whole hysterical delinquency is a reaction against internal fear of loss of love, combined with an unconscious impulse to obtain revenge for neglect. It is significant that in most cases the upbringing is found to be of a loveless type and that traumatic emotional episodes in childhood are common. Indeed environment factors during childhood play an important part in all forms of delinquency.

It is convenient to describe here those *impulsive acts of violence or injury that are associated with difficulties in pubertal development*, in particular where an active pubertal phase develops precociously in an otherwise rather unstable child. For although, strictly speaking these are transient forms of character disorder, they have many resemblances to hysterical forms of delinquency. As a rule there is a history of early and traumatic observation of sexual activities together with an obvious lack of sexual education. Such cases are readily amenable to psychological handling.

As might have been expected a great deal of compulsive delinquency is obsessional in type. Indeed but for the fact that compulsive delinquency involves injury to the property or person of others and that it usually runs in cycles, the resemblance between *obsessional acts of delinquency* and the rituals of obsessional neurosis is extremely close. The classical case is that of so-called kleptomania where the delinquent behaviour is usually in contrast to the social background or upbringing of the individual and where the objects stolen or damaged are either comparatively valueless or are not converted to the delinquents use. Actually closer investigation of many cases of obsessional stealing, whether these involve valuable or comparatively worthless objects proves that the objects stolen have a fetishistic value and are often collected and preserved without use. But the majority of cases of obsessional delinquency are not of this type. At first sight the theft does not seem to differ from ordinary stealing. A little investigation however shews that the delinquent actions follow states of emotional stress and are sometimes heralded by mild confusion. They also follow any situation where the individual feels himself to be injured by external circumstances or by authorities. The unconscious sexual organisation is of a pre-genital type and the sensitiveness to hurt indicates a strong oral-sadistic as well as anal-sadistic constitution. Whereas, however, the obsessional neurotic turns his unconscious sadism against himself, the



compulsive delinquent, by attacking external objects, not only gratifies his sadism directly but courts or receives punishment by society. Unconscious guilt-reactions are concealed by this system of externalised aggressiveness; the compulsive delinquent rarely experiences conscious guilt and accepts punishment with an apparent fatalistic (actually masochistic) indifference. When the delinquency occurs in the absence of immediate sources of stress or injury, the recurrence of delinquent acts gives the impression of a cyclical state. And indeed the underlying organisation is frequently depressive in type.

By way of contrast the *paranoid type of delinquent* acts as if he were a judge of society which he attacks (punishes) for its alleged delinquency (i.e. unconsciously, its apparent refusal of love). The element of projection has the same unconscious function as in pure paranoia. The least favourable types of delinquency are schizoid in type. Such individuals are frequently vagrant in habit and their delinquencies tend to have a bizarre form, e.g., arson, hayrick burning, cattle maiming, etc. Psychotic delinquencies are as a rule easy to diagnose, but pre-psychotic forms occurring in mid-adolescence often require examination at frequent intervals before a definite diagnosis can be arrived at.

As in the case of character disorders, classifications based on correspondence with psycho-neuroses and psychoses by no means exhaust the varieties of delinquency. In many instances the unconscious function of delinquency seems to be compensatory. With increasing experience a great number of special types will no doubt be isolated. Already many characteristic syndromes have been recorded. A typical example is that form of compulsive delinquency observed in adolescents of a narcissistic type. They have a strong latent or unconscious homosexual disposition and consort with or are taken up by people of a superior social position. The delinquency usually begins after this intimacy is strongly established; it is rationalised on the score of having to keep up appearances, but the operative factor is an unconscious ambivalence, to the patron-object which may find vicarious satisfaction in delinquent acts.

## 5. PSYCHOPATHY.

Increasingly common use of the terms 'psychopathy' and 'psychopathic personality' plunges us once more into discussion of psychiatric classifications. At first sight, and as the derivation of the word would suggest, this diagnostic label appears to be forced on the psychiatrist by the necessity of distinguishing a large group of disorders which have many characteristics in common but which cannot be conveniently shoe-horned into more familiar psychiatric sub-divisions. And it would follow from this view that, when more fundamental analysis of ego-

structure and emotional and behaviour deviations is affected, the group will be stripped of many of its existing ramifications.

On the other hand it cannot be questioned that the term has its uses, that it covers a number of well-defined clinical entities and that failing other labels, it is both convenient and necessary to employ it. It is desirable, however, to avoid confusion in its use and to limit its connotations to a practical (clinical) reference. And here it can be maintained with some justification that although psychopathy and social disorder are not co-terminous the degree of abnormal social reaction usually present in psychopathy is a determining factor in its diagnosis.

To repeat earlier formulations on the subject of classification, we can distinguish (a) symptom-formations (the psycho-neuroses) in which the ego (or the individual's normal character) is not disordered, although of course severely handicapped; (b) regressive states (the psychoses) in which the ego is definitely affected by the diseased process, i.e., the character reactions are altered but along strictly psychotic lines; (c) transitional states (drug addiction group) in which the character is, as a rule, also disordered; (d) psycho-sexual abnormalities in which the character may or may not be involved and (e) character disorders which may exist in the absence of either neurotic, psychotic, or psycho-sexual abnormalities. Now it is to be observed about these character disorders, that they are readily divisible in 'private' and 'social' varieties respectively. In the former case the brunt of the disorder is borne as it were privately by the ego; in the latter, social relations are so disturbed that it is reasonable to presume defect of those ego-institutions that are concerned with adaptation to environment. It is true that even private character difficulties, e.g. the obsessional character may adversely affect social relations; nevertheless like many symptom-formations they are not primarily social.

Now it is interesting to note that if we eliminate types of disorder that are predominantly neurotic or psychotic, character changes that are not primarily 'social', and sexual disorders in which the normal character is not affected, we are left with a group of conditions that correspond closely to those originally described as moral insanity and moral imbecility and later termed *psychopathic states*. According to Prichard's account these are characterised by disorder of feeling, temper and habit, marked perversion or depravity of moral principles or actions and loss of diminution of self-control. Such persons are incapable of conducting themselves with decency or propriety, fall readily into states of anger and impulsive action, are eccentric and delinquent in conduct, practise singular and absurd habits and are unable to fit into the fabric of society.

In course of time many other conditions were grafted on to this parent concept, and all sorts of sub-divisions were effected, to say

nothing of numerous etiological formulae. Some of these were subsequently dropped to be replaced by others; but few additions to the original account were found necessary. The fact was stressed that the psychopath's sexual impulses are morbid and excessive, that the intellectual level may be either high or low, that the behaviouristic disorders are recurrent and episodic and that the individuals are egocentric, irritable and emotionally unstable. Then came divisions into active and passive types, aggressive and inadequate types, constitutional states and personality deviations, hysterical, obsessive, hypochondriacal, eccentric, suicidal, depressive, alcoholic, epileptic, paranoid, schizoid, and sexually perverted sub-groups. The hysterical character for example was and still is regarded by some observers as psychopathic in nature and certainly the true psychopath does exhibit love of prestige and limelight which he gratifies on the shallowest of grounds. Nevertheless the hysterical character is much better understood as a selective character deviation having a strictly limited range and a specific etiology.

The truth is that many of these complications in classification are due to lack of information as to underlying structure and dynamics. The 'inadequate' psychopaths are on the whole better accounted for under other headings and it seems justifiable to relegate psychopaths whose main symptoms can be explained in terms of neurotic or psychotic mechanisms to the standard psychiatric groupings. For example although the schizoid psychopath can be distinguished from other schizoids, it is more appropriate to consider both conditions as character variations exhibiting schizophrenic mechanisms. And the same can be said of suicidal, epileptic and other types. By so doing the anti-social types are brought into greater relief. And in fact it is undeniable that persons showing simultaneously instability and perversion of ego-structure, of the emotions and of the instincts which have persisted from childhood and are refractory to ordinary influence not only constitute a high proportion of delinquent cases but a not inconsiderable percentage of the ordinary population. Certainly their incapacity to adapt to ordinary conditions of life gives them a prominent place amongst the social disorders.

A better understanding of the early environment factors conducing to psychopathy has been gained through study of transient psychopathic reactions observed amongst evacuated children in wartime. But this does not exclude either constitutional or endopsychic factors. The absence of guilt observed in delinquent psychopaths is a clear indication that early disorder of the ego in particular of the super-ego institution is a characteristic feature. The frequency of sexual perversion points in the same direction. But there are also deep disturbances of *reality valuation* which together with the blind and impulsive gratification of negativistic and acquisitive instincts distinguish psychopathy from other conditions.

One of the simplest factors which nevertheless clouds all discussion of moral and criminal responsibility is that, although the intellectual faculties of the psychopath are usually unimpaired, rational thought has no time value for him. The psychopath who absconds with the club funds knows perfectly well what he is doing and what the consequences will be. But the knowledge is of no use to him. He cannot see more than thirty minutes ahead. Nor can he value in retrospect; so that when he is finally apprehended, he has no more guilt than would an observer of the delinquency. When he is 'punished' he is just as indignant or 'injured' as would be an innocent onlooker wrongly convicted.

## Chapter XVI

## PSYCHO-ANALYSIS OF CHILDREN

It was inevitable that in course of time practising psycho-analysts should begin to specialise in different branches of their science and not at all surprising that the first of these special branches should be the psycho-analysis of children. Although Freud's original discoveries were made on the strength of analysis of adults, the burden of these discoveries was that the root causes of mental disorder could be traced to factors operative during infantile phases of development. Indeed it was one of the most remarkable of Freud's achievements, that he was able to give an amazingly accurate outline of the mental development of children, as it were, at second hand. Very few direct observations of children were utilised, and the first 'analysis' of a five year old child (the famous case of 'Little Hans') was conducted by Freud through the agency of the parents who acted as go-betweens.

This state of affairs was soon remedied. At first psycho-analytic observation of children was conducted less for therapeutic reasons than to corroborate the findings already arrived at by adult analysis. But soon the pressure of parental need led to the application of analytical therapy to the mental disorders of childhood. The clinical and technical difficulties encountered during the process were ultimately responsible for the creation of a special branch of child-analysis. For although it is true to say that the mental structure of a six year old child does not differ materially from that of the average grown-up, the mental function of younger children differs as much from adult function as psychotic behaviour differs from normal behaviour. Indeed there is something to be said for the view that 'normal' phases of infantile development bear a functional resemblance to the psychotic and neurotic manifestations observed in adult life. This is borne out by the fact that both the psychotic and the neurotic symptoms of adult life depend on a *regression* to infantile modes of reaction. This correspondence cannot, however, be pushed too far. *In the clinical sense a child has a sense of reality that is just as adequate to its conditions of existence as the reality sense of a normal adult is adequate to his conditions.*

As analytic technique came to be applied to still younger children, the main difficulty encountered was however, one of communication. Strictly speaking it is incorrect to talk of psychoanalysing children until two conditions are fulfilled; first, that the child evinces some appreciation of the relations between itself and the nearest familial objects, and, second, that it has sufficient command of language to

understand simple talk about these relations. Another difficulty lay in the fact that a young child cannot be expected to submit its mind to the discipline of 'free association' on which the whole of adult analysis is based. (see Section III: The Nature of Psycho-Analysis). This major difficulty was overcome by the simple expedient of making child's play function as a form of free association. This play can be eked out, according to the age of the child, by a varying amount of verbal communication and provides sufficient material for direct analytical interpretation. The age at which adult forms of analytic communication are preferred by the child varies widely. Some children can associate in quite an adult fashion from about seven years onwards, others, particularly infantile types, prefer 'playing' up to the age of puberty. Beyond that period play technique is essential only in the cases of arrested development.

*Developmental Aspects.* Reverting to the clinical aspects of child analysis: it is obvious that success in diagnosis and prognosis to say nothing of psycho-analytic treatment of children, depends on a thorough understanding of the various stages of mental development through which the child passes, and this in turn involves a clear appreciation of differences in what might be called the *idiom of mental expression* in the child and the adult respectively.

A general outline of the child's mental development has been given in the theoretical part of this book (Section I) and it is unnecessary to repeat that outline here. It is desirable, however, to single out those aspects of infantile function that facilitate clinical diagnosis, or, in other words, that enable the observer to distinguish between normal and disordered function in childhood. These aspects can be conveniently subdivided under the following heads (1) instinctual vicissitudes (2) emotional vicissitudes (3) motor activities and physiological functions (4) sensory perceptions and awareness of emotions (5) relations to external objects (6) thinking and speech functions (7) development of conscience and social feeling.

In estimating the *instinctual* aspects of infantile development it is essential to distinguish between unconscious and conscious factors. In the diagnostic sense unconscious factors can only be inferred from various behaviouristic observations, whereas conscious factors can be directly assessed. When making these observations it is important to note the interplay of psycho-sexual and reactive (or aggressive) factors respectively. As far as *unconscious* factors are concerned, the main difficulty is to distinguish between signs of *fixation*, of *regression* and of *progression* at the various stages of instinctual primacy, and this in turn involves some estimate of the relative degree of *frustration* and *gratification* experienced by the child. This again is influenced by consti-

tutional disposition. Generally speaking it is true that excessive frustration and excessive gratification give rise to fixation. But the existence of fixation cannot be determined clinically until it is clear either that the infant is unduly slow in advancing to the next stage of its development, by which time it is possible to speak of pathological retardation or regression, or that it has made a too hasty advance to its next stage of development, a condition that can be described as pathological progression.

Accurate assessment of *conscious* factors, i.e., the actual amount of gratification afforded psycho-sexual and aggressive instincts also depends on the recognition of certain norms of function for each stage. And the assessment of these norms is to some extent influenced by the preconceptions and sometimes the prejudices of even the most skilled or trained observer. Thus varying opinions exist as to the amount of wetting, soiling, masturbation, sexual play with other children or degree of seduction by adults that can be regarded as abnormal or pathogenic. Similarly the amount of actual aggression and destructiveness that can be regarded as 'healthy' varies according to the bias of the observer. But it is safe to say that most estimates err on the side of alarmism. Moreover, the fact of constitutional variation and sensitivity makes it almost impossible to lay down any flat ruling on these matters. When in doubt the physician is well-advised to settle the problem by reference to the *total function* of the child, a procedure which more often than not prevents vulgar errors in diagnosis and prognosis. In other words, to recognise and correctly assess abnormal instinctual vicissitudes it is necessary to take into account all the other developmental factors, emotional, conceptual, and behaviouristic.

In infancy and early childhood as in the later stages of life, *emotional vicissitudes* are the most important indications of both normal and disordered function. Since however the infant is not capable of describing its feelings objectively it is all the more important for the physician to interpret any affective expressions that may be manifested. This process of interpretation is unfortunately subject to many sources of error of which the most pernicious is to read adult experiences of feeling into the reactions of the child. Many far fetched hypotheses regarding infantile life have been based on such misreadings. Obviously the main characteristics of infantile life are (a) immediacy of instinctual needs and (b) rapidity of response to frustration. Hence the first concern of the observer should be to observe the *balance of gratification and frustration*, not only during waking periods but during sleep. In the earliest stages it is not strictly correct to speak of the happiness or unhappiness of the infant; but a balance of satisfaction over dissatisfaction is certainly an indication of successful development. A dissatisfied child will almost inevitably develop into an unhappy adult.

The most certain indication of infantile frustration is *anxiety*. All

children exhibit anxiety reactions. Many of them indeed exhibit a degree of fearfulness which, were it observed in an adult, would be diagnosed as an acute hysteria or a paranoidal state. Infantile anxiety reactions can be of a 'free floating' type, readily bordering on panic: or they can be fixed to specific objects and situations. These early forms of fixed anxiety can conveniently, though not quite accurately, be regarded as phobias. The earliest fears are associated with noises or other strong sensory stimuli, with darkness or with being deserted (actually or apparently) by protecting objects. In the earliest stages, however, instinctual objects are not clearly defined; *nor are their functions understood by the infant who reacts to them as pleasure, or, as the case may be, pain-signals.* As the infant's knowledge of the external world increases, infantile fears secure a much wider range of displacement to a great variety of inanimate objects, animals, strangers, etc.

It is a plausible assumption that early anxieties when fused with emotions of dissatisfaction and associated with separation from instinctual objects are the basis of what is later recognised as *depressive* feeling, but it is inaccurate to speak of depression before object relations are consistently organised. In any case it is likely that *feelings of detachment* and of uncertainty as to its existence, are more frequently experienced by the infant than is depressive affect. Marked *lack of affective display*, in particular absence of signs of pleasure under conditions that normally excite positive affective responses, are extremely significant, either of regressive mental tendencies or of mental defect. Early manifestations of 'pleasure' or 'pain' are thus valuable indications of emotional tendencies; e.g., crowing and laughing can be usefully contrasted with whimpering and screaming. Later forms of anxiety are associated with uncertainty in motor response and are fundamentally *obsessional* in type.

From the point of view of diagnosis the most significant groups of infantile reaction are those expressed in *motor and other bodily activities* or associated with the exercise of *bodily functions*. For clinical purposes motor reactions can be subdivided into active and passive types. Restlessness, for example, can be contrasted with an apathetic motor response, precociousness in co-ordination with incoordination (or clumsiness) of movement. Thus the motor manifestations of anxiety can be either active or passive in type. Excess or diminution of curiosity are likewise significant, and are associated respectively with active or inhibited play-activities. Needless to say the dates of onset of sitting-up, crawling, and walking are of considerable diagnostic significance. Psychological disturbances of locomotion are extremely common and take a variety of forms. Motor disturbances due directly to anxiety should be distinguished on the one hand from those due to the intensity of the infant's libidinal interest and on the other from exaggerations



or inhibitions caused by the infant's aggressive impulses. The muscular system is pre-eminently adapted to the discharge of aggression as in grasping, scratching, biting, kicking, screaming, tearing objects to pieces or throwing them away.

Disturbance of or variation in the exercise of *physiological functions* are also of the utmost significance. Eating disturbances and intestinal upset are naturally the commonest forms of organic disorder in infancy and childhood, but they are also the commonest forms of psychosomatic disorder (q.v.). In addition to which there are many exaggerations and inhibitions of bodily function which indicate emotional disturbance due either to frustration or aggression. Excessive appetite, refusal of food, vomiting, persistence of wetting and soiling, constipation, colic and diarrhoea are typical illustrations of early psychological difficulties.

Observation of motor activities should always be supplemented by investigation of the *sensory functions* of the infant. Here again distinction can be effected between psychological manifestations associated respectively with exaggeration or inhibition of function. As has been pointed out curiosity can manifest itself in a number of motor (oral and tactile) activities; but it can likewise be expressed through increase or decrease of sensory function in particular of the olfactory, visual and auditory systems. Disturbance of these functions is the more important in that the early forms of word formation and later of conceptual thinking, depend for the most part on visual and auditory impressions laid down in memory traces. Consequently any inhibition of the processes of *speech* should be carefully noted. As a rule early indications of speech disorder can be detected in the form of inhibition of laughing, crying, etc.

As has been pointed out the process of *object formation* which follows the stage of primary narcissism and of primary identification is a gradual one and is influenced by a great number of factors, e.g., pleasure-pain experiences, motor and sensory activities, the importance of different forms of component sexuality and of early curiosity and aggressiveness. But it is at all times governed by two major necessities, first, to maintain positive (friendly) contact with the instinctual objects that contribute to the gratification of infantile instincts and second, to avoid disturbing these relations by negative (hostile) reactions. As however the earliest objects of the infant's instincts are organ objects, e.g., the breast in feeding, and as the earliest functions promoted by the parents are primarily physiological, the earliest psychological relations with objects are 'mixed'. Gratification and frustration are constantly and closely associated. Fortunately this state of affairs is frequently interrupted by the prolonged regressions to primary narcissism occurring in sleep. Hence the earliest relations to objects are characterised by

what might be called an 'appropriate instability'. In other words instability in early object relations is not necessarily a pathological or even regrettable state of affairs. Once object relations are more permanently established the reaction known as *ambivalence* begins to be organised and at this point its importance as a pathogenic agent is more easily recognised.

It follows therefore that the earliest forms of disturbed object relationship are to be found during the exercise of nutritional and other bodily functions. This is very obvious in the case of sucking, weaning and other eating difficulties, also in the reactions to whichever excretory disciplines may be imposed. As the processes of inhibition grow, however, manifestations of ambivalence to objects are much more indirect and can only be inferred from, e.g., inhibitions of *response* to objects and various forms of turning away or turning in (introversion of libido). Aggressive attitudes can also be detected most readily in the development of 'free' play, a fact which has an interesting bearing on the tendency of adults to 'organise' child's play, thereby inhibiting the free expression of aggression. When in course of time recognition of both parental objects is fully established the more traumatic phases of ambivalence are gradually mastered, since the child is able to distribute its libido and aggression more effectively from one parent to the other.

Once this phase of object formation has been reached anxiety is partly transmuted into guilt and new forms of protection against emotional conflict are made available. Hence the date of onset and strength of *conscience formation* are of considerable clinical significance. The earliest forms of social anxiety displayed by the child differ from the social anxieties of the adult, in that they precede true guilt formation, whereas the social anxieties of adults are largely influenced by pre-existing unconscious guilt which by a process of projection is felt as disapproval from without. Obviously a balanced development of super-ego nuclei together with a satisfactory organisation of the various components of unconscious conscience is a prerequisite of normal development. Retardation or absence of development of some components of the super-ego and excessive or precocious growth of certain super-ego nuclei is certain to give rise to mental disorder both in childhood and in later life. In childhood these disorders take the form either of inhibition of normal libidinal and aggressive activities or of compulsive sexual and/or anti-social conduct. Excessive resort to social anxiety as a means of controlling instinctual tension is a sign that the growth of internal (conscience) reactions is already unsatisfactory. And the same may be said of over-frequent tantrums or phases of compulsive infantile masturbation.

In this outline of developmental aspects attention has so far been directed to the earliest embryonic phases of mental development which

are brought to a close from about the age of two years. They have been emphasised because they are the most difficult to assess and because *this early period is responsible for a pre-disposition to mental disorder*. A great deal of what is called constitutional disposition (a phylogenetic factor) is actually ontogenetic in nature, occurring however at a stage when clinical manifestations are very difficult to interpret and are therefore liable to be overlooked by the casual or unoriented observer. Later stages of child development are characterised by the organisation of previously isolated inhibitions under the direction of the super-ego. At a still later stage the ego succeeds in effecting these inhibitions as a matter of course. They become ingrained as ego habits or character traits. These fixed ego-formations can be easily observed from the age of three onwards. They multiply rapidly as the period of latency approaches. This is only natural since the appearance of latency marks the abandonment of the final infantile stage of parental attachment – the Oedipus situation.

No clinical assessment of developmental factors in childhood can be regarded as satisfactory which does not distinguish between true endopsychic factors and *environmental influences*. In the earlier infantile phases, environmental factors tend to be neglected even by otherwise experienced psycho-analysts. Those who attribute precocious mental capacities to the suckling appear to neglect the logical conclusion arising from their hypothesis, namely, that if the child is so precocious, environmental factors must exert a greater *reality* influence than has been supposed. In general the tendency of most observers is to regard environmental factors occurring in early infancy as having a mainly physiological effect, hence the stress on regular feeds, disciplined hygiene and the like. The fact is however, that emotional security is more important than an orderly physiological time-table. An emotional hurt may be more traumatic even than a beating, certainly more disruptive than an illness or accident. Many children are regarded as having been 'happily brought up' in a 'good' family atmosphere, and indeed themselves maintain in later life that they had a good upbringing and a happy childhood, who in fact have suffered from traumatic states of tension, ambivalence and insecurity. The only satisfactory way, therefore, of estimating environmental factors is to read them in terms of their psychological and mainly emotional effect on the child and to check them by reference to the child's existing emotional reactions and conduct. A 'well brought up' child who exhibits precocious inhibition or anti-social characteristics is either suffering from serious endopsychic disorder or bad (psychological) environmental conditions. Diagnosis in such cases can be arrived at only by a meticulous assessment of known environmental conditions – weaning, sleeping habits, excretory disciplines, parental interference or obstruction, the birth of rival children,

the amount of direct parental security afforded, the severity or rigidity of moral, ethical and other behaviouristic codes enforced, disturbance of the family setting by separation, divorce or by continued friction between the parents. It should be remembered that most parents, despite their solicitude for their child's welfare, are loathe to recognise that their mode of upbringing may have resulted in the emotional starvation of their offspring. The smaller infants being unable to speak very clearly are not in a position to correct the parental assessment of upbringing. Many analysts fall into the error of thinking that the difficulties of childhood are never due to parental ignorance, stupidity or hostility. This error is due partly to emotional bias and partly to simple lack of imagination.

*The Normal Child.* It is clear from these developmental considerations that diagnosis of mental disorder in childhood calls for much finer discrimination than does diagnosis of adult disorders. This is due less to the fact that the infant is unable to co-operate effectively during psychological examination than to difficulty in establishing hard and fast norms of function for the various stages of childhood. It is quite impossible to apply adult standards of normality to the child. For although there are many and close resemblances between some of the psychological symptoms observed in children and some adult psychopathological states, the conditions under which such childhood symptoms appear vary as regards both internal stress and environmental influence. Moreover the symptom-formations and character disturbances of the adult act as the *main channels* of discharge of pathogenic energies. In the case of infants and children this element of canalisation though present is much less obvious. Almost every function can become the playground of psychological disturbances. The everyday physiological functions of the child, its motor and sensory activities and its early forms of play, phantasy and reality adaptation are much more grossly interfered with by mental stress than are similar activities in the adult. For this very reason some of the old Victorian standards of child-normality, although based on non-psychological considerations, have acquired a degree of psychological validity. It used to be thought that if a child slept peacefully, had a normal appetite and digestion, walked and talked at the appointed time, was robustly destructive and reasonably curious, it could be regarded as normal.

This matter-of-fact assessment is not very wide of the mark. But it does not take into account that what is normal for one child may be abnormal for another. Precocity or avidity in learning may in one case be a sign of healthy development – in another it may be a sign of anxiety. On the other hand it is undeniable that 'symptoms' occur in perfectly normal children and must be estimated according to the particular case.

Anxiety reactions, eating disturbances, difficulties in dressing, fear of being left alone, of darkness, of animals, of noise, oversensitiveness, depression, difficulties over excretory functions, bed-wetting, soiling, disgust, overcleanliness, a number of idiosyncracies of behaviour and inhibitions of thought and awareness are to be found in most children, and must be to some extent discounted when arriving at a diagnosis of clinical disorder. Perhaps it would be better to say that they *should not be assessed in isolation and must be correlated with the child's general attitude and character and the degree of emotional stress under which it lives*. In short the child psychologist is constantly faced with diagnostic dilemmas. On the one hand he must avoid the danger of overlooking or minimising symptoms of child-neuroses or child-psychoses; and on the other he must refrain from being alarmist about 'symptoms' which, with proper understanding and environmental handling, would disappear in course of development.

A similar difficulty arises in the case of psycho-sexual manifestations during childhood. As has been pointed out the general tendency of parents, child minders and doctors is to regard such manifestations as disquieting if not alarming. This valuation is applied in particular to infantile masturbation, scatological orgies, exhibitionism, sexual curiosity and minor scenes of sexual seduction by contemporaries. In passing it is to be noted that a history of 'passive' sexual seduction cannot always be taken at face value since many children with passive and masochistic sexual aims succeed in exciting other more active children to seduce them. Difficulty in establishing normal standards of psychosexual activity is increased by the factor of parental interference, as the result of which normal manifestations may be unduly inhibited or alternatively converted into compulsive symptoms. It is safe to assume, however, that throughout the various stages of child development but particularly in the earlier narcissistic stages, when autoerotism is a natural pleasure, gratification of the various components of infantile sexuality is a healthy manifestation. It is in fact limited only by the adult standards imposed by parents. Apart from this, normal sexual activity in childhood varies widely in quantity, quality and range. A diagnosis of abnormality can be arrived at only when compulsive phases of activity are immediately followed by reactions of anxiety, depression or aggressiveness, or when the total function of the child is observed to be disturbed.

#### CLASSIFICATION OF DISORDERS.

Owing partly to the immaturity of mental organisation and partly to the rapid vicissitudes of early mental development the clinical manifestations of mental disorder during the first five years are extremely

'fluid'. Symptom-formations begin to manifest a classical outline only during the latency period. Early symptoms are also more closely associated with disturbances of functional development. A symptom-formation may, for example, give place to an inhibition of function; or an inhibition may disappear to be followed by a symptom-formation. Again, disturbances of psycho-sexual development may be replaced by disturbances of non-sexual function. And *vice-versa*. Despite this dovetailing and variability, it is convenient to classify the mental disorders of childhood in two main groups (1) disturbances of function and development and (2) symptom-formations which in some respects resemble the psycho-pathological states observed in adults.

*Disturbances of Function and Development* can be sub-divided in a variety of ways, e.g., in accordance with the body or mental system involved or again in accordance with the main instincts concerned. They can also be grouped in accordance with the nature of the dysfunction, whether, for example, it constitutes an inhibition, exaggeration or regression; or, again, an undue retardation of or over-rapid advance in development. Accurate diagnosis depends on a close acquaintance with the various stages of development and with the functions normally exercised at each stage, i.e., with the motor, sensory, affective and ideational activities appropriate to each period. *Each sign of disorder must be assessed in relation to the total function of the mind.* There are also certain aspects of total function which must be separately investigated. The most important of these are the capacities to endure stress, to master anxiety, to make fresh adaptations to new or stressful conditions, to establish new object relations and to assess external reality (*Reality-proving*). The disorders of function most commonly observed are those affecting sleep, eating, digestion, excretion, locomotion, co-ordination, speech, thought, phantasy, concerted action and emotional expression; or, to summarise these in terms of dynamic function, disorders of the self-preservative, psycho-sexual and aggressive systems. Exaggerations and regressions of function are comparatively easy to detect but inhibitions and retardations can be readily overlooked the more so when solicitous parents offset the child's retarded capacity by increased help and attention. Perhaps the most significant sign of disordered development is *lack of capacity for easy contact with parents, with other children and with new or strange objects.* This incapacity can be described either as a defect of object-formation or, in social terms, as lack of adaptability. It is responsible for varying degrees of shrinking or turning away (aversion) from objects. Inhibition of play activities is also a useful sign of disorder. Excessive display of aggression and compulsive autoerotic activities are also diagnostic counters. Tantrums followed by withdrawal of contact, and frequent

masturbation followed by generalised anxiety are the best examples. The main source of difficulty in diagnosis is the existence of varying degrees of mental defect. As a rule defective children exhibit a general diminution in function, whereas psychological inhibitions or exaggerations tend to be selective. Where no indications of defect exist but the spread of disordered function is extensive, incipient psychopathy or larval psychosis may be suspected. Incidentally a history of disordered infantile function as distinct from infantile symptom-formation helps to distinguish the psycho-somatic disorders of adult life from conversion hysterias.

*Symptom-Formations.* The symptom-formations of childhood though more labile than those observed in adult life are just as clearly differentiated. They can be divided into infantile neuroses, psychoses, psycho-sexual inhibitions and perversions, social (familial) inhibitions and anti-social or asocial conduct. They are usually preceded by some of the functional disorders described above. They are distinguished from functional disorders by the existence of well-defined characteristics of symptom-formation, i.e., introversion, reactivation of earlier fixations, faulty repression, return of the repressed and compromise formations (see Symptom-Formation). It is therefore inaccurate to speak of true symptom-formation until the repression barrier has been established, the pre-conscious system has been organised, a progressive series of object relations has been passed through and a super-ego system has been stabilised. For this reason the most characteristic infantile symptom-formations are not observed until the age-period of three to five years. Earlier formations do exist but are difficult to distinguish from functional disorders.

*Psycho-Neuroses.* This observation applies particularly to infantile neuroses. It is always difficult to distinguish between a true *conversion hysteria* and a psycho-somatic disturbance of function. Eating disturbances and intestinal upset are common in both groups. In earlier stages their significance varies; they may indicate the existence of deep anxieties of a 'persecutory' type; or they may be somatic expressions of a temporary frustration-anxiety. Intestinal disturbances of neurotic origin begin to appear in the second and third years and by the fourth to the fifth year true conversion phenomena affecting eating, digestion, excretion and a number of other bodily systems can be readily diagnosed.

As has been pointed out, all children exhibit *anxiety reactions* either of a 'free floating' type or fixed to specific objects and situations (*primary phobic reactions*). Many early somatic disturbances are simply expressions of free floating anxiety. Earlier forms of incontinence, sweating, vomiting, respiratory congestions and skin eruptions

are of this type. Once primary fixed anxiety begins to be organised and to concentrate on one specific object or situation, the presence of true *phobia-formation* may be suspected. *Anxiety states* are usually mixed, e.g., phobias are commonly associated with night-terrors. Phobias are more easy to detect when the child begins to pass from its excretory phase of organisation to the infantile genital phase. They represent fear of loss of love or of injury at the hands of the parents. These fears are then displaced to the phobic object. The true sources of the fear however remain disguised, viz., ideas of genital injury, castration, mutilation or destruction of the organs of infantile sexuality as a punishment for infantile sexual desires and/or masturbatory activities. This fear is increased by the child's frustration anxiety, which gives rise to sadistic attitudes towards the parents. These attitudes are then dealt with by projection on to the parents who thereby appear to be more dangerous to the child. The next step is the displacement of anxiety to non-parental objects or situations of desertion – the dark, being alone, strangers, animals, etc. The reactions to inanimate objects are animistic in type, i.e., the child behaves as if they were alive and potentially hostile. Nevertheless the phobic reaction is activated by libidinal tensions.

Between the phase of primary phobic reaction and the phase when true hysterical phobias occur, i.e., in the period between two and four years of age, it is usually possible to detect an *obsessional phase*. It is open to question whether obsessional reactions observed at this period are of exactly the same nature as the obsessional symptoms of an adult neurosis. But at least it can be maintained with certainty that this obsessional phase determines the quality of the regressions that later contribute characteristic features to an adult neurosis. It is expressed in ritualistic and compulsive behaviour, e.g., bedwetting (though this can also appear as a hysterical manifestation), habits, spasms or tics, headbanging, nail-biting, nose boring, touching ceremonials and cleanliness compulsions. Many habits commonly regarded as signs of 'naughtiness' belong to this obsessional phase, e.g., difficulties in dressing or undressing, washing, going to the lavatory, eating at table, going for walks etc. Rapid alternation of activity and passivity in behaviour is also of obsessional significance. Some rapid alternations in mood from 'feeling good' to 'feeling bad' are also obsessional in nature and are often mistaken for cyclothymic reactions.

The exact significance of *inhibitions* is difficult to determine. Many of them are functional in nature but when they are exaggerated and directed to one or two specific activities they may be regarded as obsessional or at any rate psycho-neurotic. Inhibitions of play or of the intellectual faculties, particularly of curiosity, belong to this group. Differentiation from pre-psychotic inhibitions is not easy.



*Psychoses.* Perhaps the most difficult and responsible task with which the child-psychologist is confronted is the recognition of psychotic reactions in childhood. In the psychoses of adult life it is possible to arrive at a reasonably accurate diagnosis by estimating the degree of disturbance of reality sense. But this diagnostic sign is of little value in childhood. Although normal children have at all stages of development a reality sense which is perfectly adequate for the conditions in which they find themselves, they indulge more in regressive behaviour (whether pleasurable or painful) than do adults. Quite gross interference with reality sense may be either masked or disregarded as normal fluctuations in adaptation to environment. Moreover it is at all times difficult to determine whether the abnormal reactions of children are due to disturbances of functional development, to psycho-neurotic mechanisms or to a psychotic disposition. Accuracy in diagnosis must therefore depend on a summation of factors.

The history of the first eighteen months is all important in such cases. In particular signs of incapacity to endure stress are significant. Persistent disturbances of sleep, excessive anxiety-reactions, profound disturbances of body function, especially of nutritional processes, marked incapacity to pay attention to external objects, violent muscular crises of the tantrum type or persistent inertia occurring in the first two years of life are extremely suggestive. The nature of primary phobic reactions should be carefully studied. Violent concentration of anxiety on a number of familiar objects, particularly if the actions interfere with normal functions, are signs that the infant is psychologically 'ill'. An exaggerated sensitivity to dirt on the skin, if not induced by parental faddiness, is significant. The very greatest attention should be paid to the nature of its emotional reactions to parents or nurses. Incapacity for rapport and transference is pathognomonic. Sexual activity is usually precocious and compulsive. Diminution of an existing capacity for emotional enjoyment, which is in any case abnormally low in psychotic children, is a danger signal. Morbid inhibitions or outbursts of violence can also be observed following any delay in gratification, e.g., delay in feeding or difficulties in swallowing.

Differential diagnosis between psychotic and neurotic types of child reaction is difficult, all the more so if some degree of backwardness is present. Nevertheless there are some forms of anxiety which both quantitatively and qualitatively suggest a psychotic reaction of a persecutory type. The same is true of the infant inertias which correspond to the depressive reactions of the adult. It is, however, difficult to distinguish depressive from schizoid reactions except where cyclothymic types of behaviour are present. Some early psychotic reactions are wrongly diagnosed as psychopathic.

*Psycho-Sexual Inhibitions and Perversions.* It has already been indicated

that dependable norms of sexual function have not yet been established. Standards of excessive or inhibited activity must therefore be established for each case, having due regard to the total function of the child and the presence or absence of other signs of abnormality. The main source of error in diagnosis is to regard any form of infantile sexuality apart from genital activity as perverted and absence of activity as normal. The infant's sexuality being polymorphous and being contributed from various sexual zones is not in itself perverted, and can only become so when a defensive regression is made from a later to an earlier component. Thus when a child that has given clear indication of having arrived at the genital phase of organisation, takes to anal masturbation, or soiling and smearing, it is a fair presumption that he is exploiting the same defensive mechanism that brings about adult perversion-formation. Similarly a regression from sexual interest in objects to an exaggerated form of genital masturbation indicates conflict over genital incestuous impulse. A good deal of overt sexual activity displayed from the second year onward is already compulsive and ritualistic and is often accompanied by manifestly ritualistic habits, skin picking, body rocking and the like. At a later stage it may give place to inhibitions of non-sexual functions and capacities e.g. slowing down of play activities or retardation of intellectual faculties.

*Social Difficulties.* Like the social difficulties of adult life the social disorders of childhood can be divided into inhibitions and 'perversions' of social function. Although present from the age of two onwards, they are not usually recognised until the fourth year when opportunities for social contact rapidly increase. Social inhibitions are mostly of the anxiety type, resulting at first in various forms of shyness and shrinking and later in an incapacity to learn. The more obsessional types are expressed in ritualistic habit and are usually accompanied by sharp aversions to intimacy both in the family and without. Inhibition of familial contact is usually a sign of more serious disorders.

Anti-social reactions although not officially recognised as delinquent conduct until the statutory age is reached are common from the age of three. Tantrums of a destructive type, compulsive acts of violence and early forms of stealing either from the home or at kindergarten are frequent. As with the later forms of classified delinquency they can be divided into the usual groups; neurotic, psychotic, characterological and defective. Just as normal inhibitions are a feature of development from the age of four onwards, so delinquent conduct becomes more clearly defined as the child nears the latency period. Pathological lying (*pseudologia phantastica*) makes its appearance at this stage but is merely an exaggeration of earlier preoccupations with phantasy and day-dream. It is essentially an obsessional reaction but is also a defence against frustration anxiety.

*Latency Manifestations.* The conditions described above are found during the infantile-familial period of development which ends as a rule at the age of five years. It remains to indicate briefly the influence on mental disorders of the *latency period* which extends from five to the onset of puberty. Naturally, increased inhibition of primitive impulse is the rule; but it operates more constantly through the mechanisms of character-formation. The first consequence of this increased inhibition is that the various functional disorders of infancy tend to disappear. Such symptoms as remain are drawn into the orbit of true 'symptom-formation'. Neuroses take on a more classical form and cannot be distinguished from those occurring in adult life. Hysterias, however, tend to recede in latency. Obsessional formations on the other hand may become more acute particularly in the immediate pre-pubertal phase. Psychotic tendencies are more or less masked by character peculiarities. During infancy it is difficult to distinguish between a potential psychopath and a potential psychotic but in latency psychopathic tendencies can be recognised in more or less adult form. Juvenile delinquency falls into mainly hysterical, obsessional and psychopathic forms. These should however be distinguished from outbursts of delinquent behaviour due to pubertal anxieties.

*Evaluation of Child-Disorders.* Etiologically regarded most of the exaggerations or abnormal inhibitions of function that feature so prominently in childhood can be related to unconscious phantasies of a sexual or aggressive type which induce anxiety or guilt, but, particularly in early childhood, the influence of environmental factors in bringing out these difficulties is much greater than in adult life. Avoidable frustrations, psychological mishandling, moral bullying, punishment, rigid parental inhibition and interference tend to set up a vicious circle. The child normally projects its own hostilities into external objects and mishandling not only confirms its worst unconscious suspicions but increases its anxiety-readiness. Children can, however, withstand a good deal of maltreatment, and masochistic types with early super-ego formations may even appear to thrive on it, although to judge from the difficulties they encounter in later life the appearance is often deceptive.

Accurate evaluation of the psychological symptoms of childhood is of importance for prognosis. And obviously it is of inestimable value to parents if the physician is able to indicate in advance what difficulties their child may have to encounter during later development. Three main possibilities exist; (a) the symptom may persist into adult life, as when aversion to certain foods, intellectual inhibition or fear of the dark remain unaltered, (b) it may appear to diminish but in fact undergo displacement, as when difficulties in food intake are replaced by difficulties in intellectual apprehension, (c) it may disappear as a symptom to

reappear as a characterological or behaviour disorder. Apart from this the existence of an infantile neurosis is a prerequisite of the development of an adult neurosis. Even if infantile disorder should disappear spontaneously, the utmost care should be taken to avoid situations of psychological stress in later childhood and to choose the most appropriate environmental setting both educational and social.

*Recommendations for Treatment.* It follows from these considerations that there can be no hard and fast rules regarding recommendation of treatment. Cases may present an almost identical symptom-picture yet require quite distinct measures of treatment. The factors to be taken into account in making any recommendation are (a) the constitutional predisposition of the child, in particular its sensitiveness to frustration and emotional stress, (b) the nature of the disorder and, (c) the amount of strain imposed on the child by environmental conditions and upbringing. It should be remembered that while on the one hand the mind of the average child is able to resolve unaided a considerable amount of conflict, it may on the other hand break down under the strain of later and apparently less important emotional situations. Even so, the 'last straw' causing a breakdown may not take effect until after a lapse of time. Many latency disorders are in the nature of postponed reactions to earlier strains.

The bearing of this on treatment is obvious. Cases where environmental factors appear to have determined the breakdown should be treated by appropriate alteration of the environment. Environmental therapy is also indicated where functional disturbances are due to immediate anxieties or hostilities. Symptoms sometimes disappear after the child is reassured about the normal exercise of masturbation. Many obsessional reactions disappear when an over strict disciplinary ritual of cleanliness is modified by the parents. Inertia and infantile depression can frequently be corrected by more adequate display of parental love and interest.

The indications for child analysis do not differ very much from those which apply to the analysis of adults (see Section III). There are however two schools of child analysis. One holds that owing to the immaturity of the child and the fact that its mind is in process of development a preliminary stage of ego-education is necessary for successful analysis, the other maintains that no essential modification in the technique of child analysis is called for, apart of course, from the use of play association with young children. These differences reflect different valuations of the factor of transference in small children. Certainly modifications in the application of standard techniques are called for in the case of children. Indeed they are just as unavoidable as in the case of adult psychotics and psychopaths. But they need not involve systematic measures of analytical pedagogy. The analyst who sticks to a rigid

technique in the analysis of children is courting failure: and as a rule the child solves the dilemma by shaping the analysis to his own ends. As in the case of adult analysis it is easy for the patient to circumvent the analyst by abandoning symptoms for the time being. Should a recommendation of child analysis be decided upon the sooner it is carried out the better. Early analysis may save the child from more disastrous breakdown at a later period. Nevertheless analysis should not be recommended as a matter of routine. Indications for treatment should be strictly adhered to. As the mostly unsatisfactory results of 'prophylactic' analyses (i.e., analysis of children whose parents are interested in psycho-analysis) clearly shew, diagnosis is not enough. The case must not only need treatment but be suitable for treatment. In doubtful cases these points can be determined by carrying out a probationary or observation analysis for a week or two. The physician may, however, decide that the parent rather than the child requires analysis. And no doubt in many cases much better results would be obtained by analysing the parents rather than the child. But that applies only where environmental mishandling is the main cause for the child's illness. Should the parents refuse to follow psychological advice and persist in mishandling the child, the physician is placed in an awkward dilemma. The condition of the child may call for an extensive period of withdrawal from home life. But unless a suitable foster-family is available, removal from home might simply be out of the frying pan into the fire. Moreover it is almost always true that even a 'bad' family is better than a 'good' institution. In such cases the family doctor cannot do better than evoke the assistance of a trained child psychologist, having first of all taken the precaution of finding out that the specialist does not have any fads of his own on the matter of child-upbringing.

### *SECTION III*

#### PRACTICAL APPLICATIONS

- A. Examination    B. Diagnosis    C. Prognosis
- D. Recommendation of Treatment
- E. The nature of Psycho-analysis    F. Duration of Treatment
- G. Cost of Treatment    H. The Choice of Psycho-analyst
- J. The Family Situation.    K. The Results of Treatment.



## *Chapter XVII*

### A. PSYCHOLOGICAL EXAMINATION

To conduct a successful psychological examination five principal qualifications are necessary: first, the capacity to make easy and sympathetic contact with individuals in a state of mental suffering or malfunction; second, a good understanding of the various groups of psychological disorder and of their comparative significance as indicators of unconscious conflict; third, familiarity with the outlines of the 'normal' personality and with the various sub-divisions of 'normal' character; fourth, the ability to estimate the total mental function of any given individual; and, fifth, the capacity to assess the patient's state of rapport with his familiars.

Some of these qualifications depend on the natural aptitude of the examiner, which may be either enhanced or inhibited by his unconscious reactions to mental conflict. Left to their own devices most practitioners tend to approach organic disorders more sympathetically than they do mental disorders, which in fact often arouse in them a degree of impatience or irritation. When this is the case it is unlikely that the observer will be able to assess either the total mental function of the patient or his capacity for rapport. These estimates are often made intuitively; and sound intuitions cannot be formed in a state of prejudice or disapproval. It would be wrong, however, to suggest that some degree of empathy cannot be acquired through experience. Even highly trained medical psychologists may find themselves at home with some forms of disorder and out of tune or sympathy with others; and although this handicap can best be overcome by a thorough analysis of their subjective bias, it can be mitigated through increasing experience and arduous study. In any case the most gifted intuitive cannot diagnose successfully without clinical orientation.

From the clinical point of view the physician should be familiar with the main classifications of neuroses, psychoses, sexual inhibitions and perversions, and should be able to estimate rapidly their depth, spread and chronicity. He should also have in parallel series classifications of domestic, marital, social and occupational difficulties, so that, for example, he can assess roughly what variety of social difficulty or sexual perversion corresponds with any given neurosis or psychosis. This involves a fairly extensive acquaintance with a variety of so-called norms of function or behaviour. Needless to say these diagnostic assets do not of themselves enable the examiner to form an accurate prognosis. Many patients who present classical symptoms of psycho-



neurosis may nevertheless succeed in maintaining, at some cost it is true, a reasonably effective adaptation to life. This is due to the fact that a psychic symptom is to a certain extent an attempt at spontaneous cure of unconscious conflict. As a matter of interest the general practitioner sees more of these 'compensating neuroses' than any specialist.

Although in course of time each examiner develops methods of approach that are consonant with his individual character and temperament, it is both convenient and desirable to keep to the same general line of approach. In this connection it is well to remember that *the primary aim of the examination is to find out what is wrong with the patient*. Many observers, carried away by the desire to resolve psychoneurotic problems in a single interview, tend to seize on the more obvious symptoms present and arrive at a diagnosis without any regard to the personality of the sufferer. Others are unduly concerned to apply within the diagnostic interview techniques that might be more suitable to a therapeutic approach. Thus they will insist on using methods of free association. Others again, biased by their hospital training, are inclined to fall back on the formal psychiatric technique of diagnosis, whereby the patient has hardly entered the room before his faculties of memory, orientation and reality-testing are subjected to a meticulous and often ridiculous examination. No doubt such procedures afford some information regarding the presence or absence of malfunction, but they do so at the cost of alienating the patient.

*The physician's first concern should be to let the patient tell his story in his own way.* By so doing he will acquire considerable information regarding the nature of the immediate problem and the character of his patient. He will in fact secure some of the advantages of free association without in any way alarming the narrator by the employment of technical devices. Some idea of the relative importance of the patient's symptoms can be gained; his spontaneous, though often inaccurate, account of their incidence and his, usually defensive, explanation of their origin can be assessed. Naturally, it is necessary to be on the outlook for both inaccuracies and omissions, all the more so that these are forms of unconscious protection. But these points can be checked later: in the first instance it is desirable not to interrupt the narrative. Using this method certain general characteristics can usually be detected: e.g. the halting and spasmodic account of his condition given by the anxiety hysteric, the endless circumlocutions and qualifications of the obsessional type, the despondent and guilt-ridden behaviour of the depressive, the negativism of the paranoid character, and the shallow emotional expression of the schizoid personality. A dependable diagnosis cannot, however, be arrived at merely by encouraging the patient to speak freely about his difficulties, and, in obsessional cases in particular such a course would certainly end in diagnostic

stalemate. As a general rule not more than one half of the time available should be devoted to obtaining a spontaneous account.

The *methods used to check the patient's own story* or to amplify it in a systematic way depend on the case. In the long run a skeletal outline of the patient's life is necessary for accurate diagnosis. This can be obtained either by working backwards from the statement of current difficulties, tracing each item to its earliest remembered or reported manifestations in childhood, or, starting in a more systematic way, by inquiring about difficulties in childhood and gradually arriving at the existing symptom picture or social state. For example, examining the history of anxiety or of phobia-formation one can commence by enquiring about night terrors in infancy, fear of the dark, etc. Having investigated a representative group of these manifestations one can trace their modification down to such sophisticated adult forms as social anxiety or stage fright. Similarly with conversion phenomena, with obsessions, compulsive rituals, or superstitions, with depressive, paranoid or schizophrenic reactions. In short, one can take the classical symptoms of the chief psycho-neuroses and psychoses, and estimate the total symptom picture at different phases of development. Examination of the symptom-picture is a 'shorthand' method of investigation. Nevertheless, provided the results are duly corrected for what might be called a normal amount of abnormality, it gives a rough idea of the seriousness of the case. It is even more useful in indicating the directions in which further enquiries should be made.

The alternative method of investigation whereby the onset of existing symptoms is ascertained, and, working backwards, the dates of earlier breakdowns is established, has nevertheless some advantages. It enables the examiner to establish the existence of precipitating factors and, by correlating these factors with the severity of the symptoms, to estimate the patient's *capacity to withstand psychic stress*. Should the developmental method of investigation have been followed, it is necessary to estimate separately these precipitating factors and reactions to stress. Indeed these factors should be kept in mind throughout the whole examination.

No psychological examination is complete that does not include an investigation of the patient's *psycho-sexual and social history*. Moreover, it is essential to examine the negative (aggressive) as well as the positive (libidinal) aspects of both sexual and social contacts. When, as is sometimes the case with sensitive individuals, an exhaustive examination is contra-indicated, preliminary assessment of symptoms enables the physician to be sparing in inquiry without missing essential points. The investigation of psychosexual development extends in a number of directions. The nature of overt sexual experiences (either autoerotic or with external objects) can be ascertained. The sexual

compulsions of early infancy and childhood together with any history of active or passive seductions should be assessed. The development of pubertal manifestations should be followed, also the form and nature of adult relations whether natural, inhibited or perverted. It will be found that this investigation shades naturally into examination of affectionate or friendly relations with objects at all stages. A parallel examination should be made of hostile impulses or suspicions occurring from infancy onwards. Special attention should also be paid to the existence of ambivalence in social or sexual relations, e.g. to a mixture of unconscious sadism with love drives, or to periodic manifestations of anti-social reactions and conduct. All this enables the physician to assess the strength of general social relations, both friendly and hostile.

Once this general assessment has been made the way is open to deal with the more ticklish investigation of *family history* and relations. In the first place the methods of upbringing followed by the parents, foster-parents or nurses, their systems of discipline, codes of behaviour, and types of psychological reaction should be investigated. The degree of harmony between the parents is a point of some importance. In the second place the patient's reactions, both friendly and hostile, to his parents should be established. The reaction to siblings should also be investigated. Ages of the various members of the family should be carefully ascertained, and the age gap between elder and younger brothers or sisters noted. Here again the factors of traumatic reaction and capacity to endure emotional stress, e.g., rivalry, hostility should be assessed. All these familial investigations should be supplemented by inquiries as to school life both in childhood and adolescence.

To complete the investigation of predisposing factors, the history of the patient's *general health* and of any organic disorders from which he may have suffered should be ascertained. These are of importance from the point of view not only of predisposition to psycho-somatic disorder, but, particularly in the case of early infantile diseases or operations, of the patient's emotional set and attitude to the family. It may be assumed that the practitioner has already made a thorough physical examination. This precaution is indispensable in cases where disordered manifestations are somatic in type and therefore must be distinguished from organic symptoms. Moreover, should the case ultimately be sent to a psychological consultant, a preliminary examination saves the latter a good deal of time and trouble. As a rule psychoanalysts prefer not to make physical examinations of prospective patients and are naturally glad to receive an accurate physical report from the physicians in charge of the case. In the absence of such information they are obliged to arrange for an organic overhaul.

At this point *working capacity*, *hobbies*, *recreations* should be estimated from the point of view of inhibition or perversion of function,

lack of concentration or proneness to exhaustion. Conclusions of importance can be drawn from the patient's *temperamental habit*: his tone or level of happiness or unhappiness, elation or depression, optimism or pessimism, openness or reserve, credulity or suspiciousness, his tolerance or touchiness, placidity, apprehensiveness, presence or absence of adequate emotional response to everyday life or crises, conscientiousness or lack of scruple, superiority or inferiority feeling: in short to what is generally called his *character and emotional set*. Wherever possible the nature of stereotyped phantasy preoccupations or systems of daydreaming at different phases of life should be ascertained. This leads naturally to an investigation of the phenomena of sleep. Characteristic dreams, particularly those persisting from childhood are often of considerable diagnostic value because of their symbolic reference to unconscious (kernel) phantasies.

A working estimate of the more *general mental functions*, e.g. of memory, orientation, will-power, concentration, etc., can usually be elicited by a few questions or inferred without direct questioning during the general examination. It should be remembered that patients are extremely sensitive on the subject of their capacities and all these questions should be put as tactfully as possible.

The next, and last, stage of psychological examination is in some respects the most difficult. It is easy to see that the spontaneous history offered by the patient is inadequate. To some extent this can be offset by systematic examination. But in making this detailed survey, the physician may lose sight of the fact that the patient's illness is essentially a life-problem. *If he has not already done so, he should, at this point, try to piece together the main patterns of his patient's life*, e.g., the instincts that have dominated the patient and the degree to which they have been subordinated to the demands of reality adaptation. To do this effectively he must be able to assess the importance of environmental factors the existence of which has been established by systematic examination. Actually, considerable divergences of view exist between psycho-analysts on this issue. In the early days great importance was attached to the occurrence of infantile traumatic episodes, e.g., seductions or observations of parental coitus. At a later date Freud made the discovery that many of these episodes were products of unconscious phantasy. And since then the accepted psycho-analytical view is that the most important factors in neurosogenesis are endopsychic. This view is reflected in the relative unimportance attached to precipitating factors in symptom formation. But it does not follow that environmental factors are of no significance. On the contrary, accuracy of diagnosis and, needless to say, of prognosis, depends to a large extent on an accurate appraisal of infantile environmental conditions. Persecutory feeling, for example, occurring in persons whose upbringing

and environment have apparently been satisfactory, is more likely to be psychotic in type than when it occurs in persons who have been persistently ill-treated, either physically or mentally, during childhood. It is important to ascertain whether traumata endured have been occasional or spread over a prolonged period. Isolated traumatic experiences are of special significance in the diagnosis of hysteria and depression, but, generally speaking, the cumulative effect of traumatic conditions over a prolonged period is more significant.

It is also desirable to make a psychological assessment of existing *environmental conditions* e.g. of working conditions, the amount of social contact, the state of economic security, success or failure in psycho-sexual relations. In making these assessments the practitioner has considerable advantages over the psycho-analyst, who, for a number of reasons, is usually debarred from exploiting second-hand sources of information. The practitioner is in a position to act as his own social worker, i.e. he can actually observe the family and social situation. He may also obtain useful information from the more discriminating among his patient's friends, though he should remember that patients are likely to resent anything that smacks of family interference. In any case the evidence of both family and friends is never very trustworthy and should be credited mainly on matters of fact.

It is obvious that an examination conducted on the lines indicated above must involve a considerable expenditure of *time* and energy on the part of the practitioner, to say nothing of the patience and psychic endurance required of the patient. Not that this is peculiar to psychological examination. The same holds true of any organic examination. But, as in the case of physical examination, the formal description of psycho-diagnostic methods does not imply that every stage of the examination necessarily involves equally meticulous investigation. In a number of cases when the disorder takes an uncomplicated and classical form, the patient's own description of his condition enables provisional diagnosis to be made in a few minutes. And with increasing experience even more complicated cases can be diagnosed in a comparatively short time. *In no case, however, should a general survey be omitted.* A homosexual may say, for example, that he has come to be treated for his homosexuality and that as far as he knows there is nothing else the matter with him. From the symptomatic point of view this statement may prove to be accurate yet it would not be possible to offer any opinion on his condition without a lengthy and detailed examination of his life and character. The fact is, of course, that as in the case of organic disorders, investigation of symptoms is only part of a total examination.

Nevertheless the question of time is an important one, since both in general and in clinic practice it is seldom practicable to make a

complete examination at one interview. Moreover since the patient is, particularly during the first interview, under considerable psychic strain it is undesirable to prolong the preliminary examination more than one hour. In the case of hypersensitive types it may have to be limited to a brief interview calculated to promote easy contact. In the majority of cases diagnosis can be arrived at in two interviews preferably at an interval of a few days. More prolonged examinations are sometimes unavoidable in the interests of accuracy. They permit the examiner not only to check false impressions but to correct fabrication on the part of the patient. Where the examination is made in the first instance by a psycho-analyst yet another consideration has to be taken into account, namely, that over-elaborate anamnesis may interfere with the spontaneous opening of a therapeutic analysis. So long as he is satisfied that he is guilty of no material errors of omission and has duly arrived at the conclusion that the case is suitable for psycho-analysis, the psycho-analyst should not *press* for detail during diagnostic interviews.

## B. DIAGNOSIS

Having collected all available information as to the patient's symptoms, his psycho-sexual and social difficulties or habits, his working capacities or incapacities, his standard temperamental reactions, and his environmental difficulties, both past and present, the physician can proceed with some confidence to effect a provisional diagnosis and prognosis. At this point he is faced with difficulties that are not of his own making. The diagnostic labels that are used in psychiatry and, for the matter of that, in general medical psychology have been handed down from an earlier epoch when clinical classifications were effected mainly on a descriptive basis and when etiological formulations were of the most rudimentary order. This usage inevitably leads to the neglect of the relation between normal and abnormal functions in any given case. To this day both diagnosis and prognosis are frequently effected on superficial and mainly symptomatic criteria. The developmental approach followed by Freud has revolutionized this procedure; it is now recognised that *neither diagnosis nor prognosis can be effected on the strength of the symptom picture alone*. The various neuroses, psychoses, perversions and character disorders, can be roughly but effectively classified in terms of the developmental stages at which their fixation points lie. And although it is still convenient to use formal psychiatric labels, no diagnosis is complete that does not include some assessment of the unconscious level of organisation, disturbance or activation of which has given rise to the symptoms observed. Depth psychology has come to stay.

The second difficulty is of a similar order. It has always been recognised that 'mixed' types, 'transitional' types and 'larval' types of disorder exist; and a great deal of psychiatric ingenuity has been expended in producing elaborate sub-divisions of these groups. But as a rule these sub-divisions merely perplex the student without affording him any compensation in the way of insight. A good deal of this confusion can be eliminated by adopting Freudian developmental standards. For example, phobias associated with suspiciousness, hostility and marked social reserve have always been regarded as of a different order from identical phobias associated with mild sexual inhibition and a potentially friendly and sanguine social reaction. This recognition was expressed in the generalisation that some hysterical manifestations mask reactions of a psychotic type. But until it was understood that the classical phobias are due to the existence of unconscious conflict over infantile genital impulses and that the more ambivalent types are due to conflict of pre-genital origin, little headway could be made with differential diagnosis. Once the respective etiology of the two groups of phobias was recognised, it was easy to look for and find corroborative material among the more normal aspects of the patient's life and character. A parallel examination of symptomatic and psycho-sexual reactions, for example, usually gives some indication of the position of the fixation point. And this can be further confirmed by an examination of character reactions, particularly the direction of ambivalence, which in the case of true hysterical types is usually focused on persons of emotional significance, whereas in the 'masking' phobias it is readily directed against comparative strangers. Nevertheless it would be a mistake to jump to the opposite conclusion and describe the more suspicious and hostile types as 'paranoid' phobias. This is proved by the fact that phobias of this kind can be more readily resolved than paranoid fears.

Using the developmental method of *assessment in depth* it is possible to distinguish between conditions which although descriptively speaking belonging to the same group, yet differ in important prognostic respects. Thus an uncomplicated contamination obsession is 'deeper' than an uncomplicated touching obsession. The former covers anal-sadistic fear, the latter conceals mostly infantile genital anxieties. Similarly obsessional neuroses with a depressive background are to be distinguished from obsessions associated with mild phobias. Obsessional reactions with a paranoid understructure e.g., associated with marked food phobias or a tendency to heavy drinking, differ from both of the foregoing types. They are more grave, although, interestingly enough, when they do take a favourable turn, they resolve more quickly and dramatically than depressive obsessions. Psycho-sexual inhibitions or perversions may be graded like phobias and obsessions. The more

primitive the perversion, the deeper the mental disturbance. Apart from this, differentiation of types depends on the presence of neurotic or social reactions indicating the level of conflict. Mild degrees of impotence correspond roughly to mild anxiety states. Hence, when impotence is accompanied by symptoms of mild anxiety, it may be assumed that the inhibition belongs to the true genital type. Marital difficulties should be assessed according to the mechanisms involved and the type of emotional reaction. The same applies to asocial or delinquent behaviour. The less primitive forms either show an obsessional type of reaction or exhibit sporadic outbursts of a rather hysterical pattern. More severe cases have a mental structure or pattern which is either paranoid or schizoid in type. Nevertheless it is undesirable to fall too readily into the habit of regarding these conditions as manifestations of a true psychosis. It would be a great convenience if some distinctive nomenclature were adopted which would provide appropriate clinical labels and at the same time indicate the depth of the disorder in question. In the case of delinquent types, this need is partly met by the use of the term 'psychopathy'; but, as has been pointed out, this term has come to include a variety of conditions differing greatly in depth of origin and to that extent has lost some of its usefulness.

The significance of 'mixed' and 'transitional' forms of neurosis depends also on the developmental level at which the conflict first manifested itself. Clinically speaking it is convenient to distinguish clearly between hysterical and obsessional neuroses because not only do they originate from different levels of fixation and activate different mechanisms, but the prognosis is also different. Similarly it is convenient to speak of a 'mixed' neurosis when the patient presents active manifestations of both an hysterical and an obsessional type. Etiologically, however, mixed neuroses spring from a level of development between that responsible for obsessional symptoms and that responsible for hysterical symptoms. The use of the term 'mixed' merely implies that the observer has not at his disposal a more suitable diagnostic label. Actually the term 'transitional' is more suggestive, indicating as it does that the condition arises from a distinct but intermediate developmental level. The author has adopted this usage in the case of alcoholism and the drug addictions which originate at a level more superficial than that responsible for psychotic reactions but deeper than that responsible for the psycho-neuroses. No doubt it is easy to avoid this difficulty by using descriptive labels such as 'drug addiction' but in the interests not only of classification but of prognosis it is essential to establish the particular level of development involved.

Unfortunately the classification of purely characterological difficulties (type-psychology) is equally inadequate. There are no diagnostic labels corresponding to those attached to neurotic or psychotic symp-



toms. Hence, as in the case of 'mixed' neuroses and 'transitional' states, it is necessary to assess each character abnormality in terms of depth or level of conflict. This task is easier when there are obvious indications of excessive function of a particular unconscious mechanism. For instance the existence of phantasies and reactions of a persecutory type involving extensive use of the unconscious mechanism of projection, to some extent justifies the use of the term 'paranoid character'. Although, to be sure, there is a vast difference between a paranoid character and a paranoid psychosis. Provided, however, this difference between a character reaction and a symptom formation is kept clearly in mind, there is no harm in using a classification of character disorders based on the resemblances they bear to the neuroses and psychoses. The obsessional character, for example, is a well defined type and so in their way are hysterical, depressive and schizoid characters. Unfortunately not all character-disorders can be shoe-horned into this set of clinical groupings; and many observers have taken the line of least resistance by labelling character disorders in accordance with some descriptive feature or some typical mental mechanism associated with them, e.g. the 'Don Juan' character type; or again the masochistic or self-injuring character, the negativistic character, the delinquent type, the miser, the spendthrift and the like.

No doubt these difficulties of classification will be overcome in due course. In the meantime, however, the student is under the necessity of learning – and this he can do by experience – a *psychic scale of measures*, whereby he is able to make *correlations in depth* between the classical symptom-formations and the characterological or psycho-sexual disorders that spring from the same levels. Thus, as a general rule sexual inhibitions, mild perversions, the simpler marital frictions, diminutions of working capacity and lack of concentration, should be placed in the same category as anxiety states, phobias, conversion hysteria and the anxiety character. Similarly psychotic episodes have on the whole the same value as primitive forms of perversion (e.g. coprophilia, violent sadism), total absence of sexual drive and capacity, grave marital disturbances, total incapacity to work and depressive, paranoid and schizoid characters. As has been indicated, however, the fact that different conditions belong to the same developmental level by no means implies that their prognosis is identical.

### C. PROGNOSIS

Whereas diagnosis depends on the *level* of disturbance involved, prognosis depends on the *degree of accessibility* of the patient. This criterion takes precedence over all other prognostic standards, for

although it is generally true that accessibility runs in inverse ratio to the depth of mental disorder, there are many exceptions to this rule. Accessibility to human influence depends on the patient's capacity to establish *transference* i.e. to repeat in current situations and in particular in his relation to the analyst the unconscious emotional attitudes developed during early family life. Transferences are in turn divisible into *positive* (friendly) and *negative* (hostile) varieties. Where negative predominate over positive transferences, the patient tends to be inaccessible to influence. Inaccessibility is of course a matter of degree and it does not follow that because he appears to be inaccessible the patient is therefore unsuitable for psycho-analysis. In this respect psycho-analysis has a considerable advantage over other forms of psycho-therapy; for whereas a superficially inaccessible case usually has a *negative reaction* to the *therapy of influence* (e.g., hypnosis, suggestion, guidance, exhortation etc.), it is possible for the psycho-analyst to make a rapid exploration of the patient's negative transference and so render him more amenable to psycho-analytical interpretation.

Employing this criterion of accessibility and bearing in mind that character disorders are more rigid than symptom formations, it is true to say that the prognosis established for the various psycho-neuroses and psychoses can be used as a measure of the accessibility of those characterological or social difficulties that correspond with them. It is generally agreed that the transference psycho-neuroses (anxiety hysteria, conversion hysteria and obsessional neuroses) respond most readily to psycho-analysis. Anxiety hysterics are the most suitable of all, particularly when associated with gross memory disturbance, or periodic interference with sensori-motor function. In fact the classical stages of psycho-analytic treatment (including cathartic crises, recovery of memories, rapid development of transferences) are best observed in these forms of hysteria. There are, of course, exceptions to this rule. Monosymptomatic hysteria (an isolated phobia in an otherwise apparently fairly stable person) is usually difficult to resolve, and phobias with any suggestion of underlying psychotic reaction should be treated with respect.

Next in order of amenability to treatment come the true conversion hysterics. This view is sometimes called in question owing to the fact that many apparently pure conversions are complicated by fixation hysteria, i.e. the organs involved have been rendered psychologically 'prone' by reason of previous organic illness. These mixed conversions are certainly more difficult to deal with because of the increased narcissism induced by prolonged or repeated illness. The same holds true of conversion hysterics occurring in individuals suffering from organic disease of other systems. Perhaps the best example is that of a gastric

neurosis complicated by organic disease of the heart. The situation allows too much defensive interplay between organic and psychological factors. In such cases therapeutic effort can be easily frustrated, and it becomes essential to delimit carefully the spheres of influence of the organic physician and of the psychologist. Nevertheless pure conversion hysterias are readily accessible to psycho-analysis; they are more difficult than anxiety states but much less intractable than the obsessional neuroses.

Uncomplicated obsessional neuroses and obsessions accompanied by anxiety symptoms have a good prognosis, although they require more prolonged treatment than cases of anxiety and conversion hysteria. The most difficult type of obsessional neurosis is that accompanied by sexual perversion or by marked hostility and suspicion. Moreover, although in hysteria resolution of symptoms as a rule comes rapidly, i.e., within three to six months, obsessional symptoms may persist for a prolonged period despite marked improvement in the general psychic reactions of the patient. In a considerable number of cases the most energetic treatment produces little more than a symptomatic stalemate. The patient is able to resume a full-time occupation and to maintain his psycho-sexual relations but continues to carry out a symptomatic routine which, although burdensome enough, no longer cripples his capacity for life and work.

The prognosis of transitional states (such as alcoholism) which lie between the neuroses and the psychoses, is uncertain; but at least a major reduction of the addiction can be expected. A great deal depends on the type of addiction. It is of course well-known that the prognosis of cocaineism is better than that of morphinism, and this despite the fact that cocaineism leads to more rapid crises of deterioration than does morphinism. But the most reliable prognostic criterion is the associated psychological disposition. Addicts with a depressive constitution do better than addicts with a persecutory disposition.

On the whole the prognosis of the psychoses is not favourable. Nevertheless undue pessimism is to be deprecated. Even without treatment the percentage of spontaneous cures is quite considerable. On closer examination, however, these spontaneous cures are found in a particular type which might conveniently be labelled as 'abortive'. In many 'abortive' cases diagnosis is effected during some early and sporadic episodes and the physician is inclined to play for safety by describing the patient as, for example, schizoid or cycloid, and by taking a grave view of the case. When the patient is a genuine 'abortive' type the latter course is however a hit or miss method. It is possible to single out these 'abortive' types by assessing not so much the reality sense of the patient as his potential transferences. Apart from this a number of psychotic cases can be considerably improved by psycho-analytical supervision.

This is more true of depressive than of paranoid, paraphrenic and schizophrenic types. And although it must be admitted that in acute and inaccessible stages of psychoses there is little scope for direct application of analytic methods, it is quite certain that if analytic principles of observation and supervision were given effect, the ultimate results in advanced psychotic types would be greatly improved. The fact is that routine psychiatric treatment of the psychoses whether by institutional methods or, as latterly, by various forms of shock-therapy, is almost wholly non-psychological in tendency. It may be expected that in course of time the prognosis even of chronic cases will be greatly improved by the routine application of psycho-analytical principles. While undue optimism is certainly to be deprecated, it is only fair to say that undue pessimism is a consequence of taking the line of least therapeutic resistance. It is essentially an institutional reaction.

Applying these standards to perversions, inhibitions and character peculiarities, a fairly accurate prognosis can be given. Generally speaking, sexual and social inhibitions are more easily reduced than the corresponding neuroses and psychoses, whereas sexual perversions are more difficult. The prognosis of homosexuality varies according to the type. Where passive elements predominate or strong constitutional factors can be presumed only the most guarded prognosis should be given. Neurotic character cases (anxiety or obsessional characters) are harder to resolve than the corresponding neuroses. Depressive character types are more rigid than true depressions. On the other hand, schizoid types, although requiring prolonged analysis, are in the long run more amenable than even mild cases of schizophrenia. Paranoid characters are perhaps the most difficult of all. Marital difficulties also vary according to mental pattern. Prognosis is more favourable when the case is taken early (within six months to two years of marriage). It should be remembered that it takes two to make a marital crisis, hence even favourable cases may not respond unless the marriage partner is analysed at the same time.

The prognosis in cases of delinquency varies according to the type. Anti-social conduct due to disturbed pubertal development is usually easy to deal with. Psycho-neurotic types of delinquency are more refractory than the corresponding neuroses, but have nevertheless a good prognosis. Simple cases of psychopathic delinquency are much more amenable to treatment than has previously been suspected. Schizoid delinquents are, on the other hand, extremely difficult to handle. Generally speaking the difficulty in dealing with delinquents lies in the fact that the patient commences treatment in a state of negative transference and is likely to repeat his offence in the earlier stages of treatment.

The accessibility of all cases gradually declines from the age of forty

but advanced age is not so much of a contra-indication as was once thought. Elasticity of mental function, comparative freedom in the flow of libido and absence of regressive characteristics are more dependable criteria. Nevertheless with persons over the age of forty a careful assessment should be made of existing environmental factors. From this age onwards the factors of *current frustration* become more and more decisive. Where frustration is acute and likely to remain so there is little chance of producing any radical alteration by psycho-analysis, although the patient may be rendered more capable of adapting to his surroundings. On the other hand particularly in masochistic types, a considerable amount of social friction can be endured and, in some cases, may protect against a neurotic breakdown. In characterological cases and in sexual perversions a bad environment lessens the probability of cure.

Where prognosis is uncertain it is better not to express any opinion until the patient has been given a complete psycho-analytical examination and if necessary a short period of psycho-analytical observation. Timorous patients should, however, be reminded that this examination may not lead to a final recommendation of radical treatment.

#### D. RECOMMENDATION OF TREATMENT

Neither diagnostic nor prognostic assessments permit an automatic decision either in favour of or against treatment. The fact that clinically speaking a case belongs to a 'favourable' group does not imply that an immediate analysis is called for, or that, if recommended, it will necessarily be a short and easy analysis. Many psycho-analysis who exercise a fine discrimination in diagnosis are apt to lose their perspective when it comes to recommending treatment. They incline to the view that because a disorder can be *explained* in psycho-analytical terms, it is therefore *suitable* for analysis. This is a beginner's error. It is true that, as has been pointed out regarding prognosis, the most important factor in treatment is that of psychic accessibility. But the fact that a patient is apparently accessible does not finally determine his suitability for treatment. Nor does it justify giving sanguine estimates as to the duration of treatment. An attempt must be made to assess the patient's 'will to recover,' both conscious and unconscious. In other words the primary and secondary 'gain through illness' should be first estimated. The *primary gain* (the maintenance of a balance of unconscious conflicting forces irrespective of the pain and discomfort caused by symptoms) is difficult to assess without a preliminary analysis. But with increasing experience it is possible to estimate the depth or level of conflict responsible for different varieties of disturbance, and correlate

this factor with the possible strength of instinctual factors. Thus the existence of conversion symptoms in men with a passive sexual disposition is not a promising combination. Similarly, marital difficulties in masochistic types are likely to afford too much primary gain for a ready response to treatment. Again, the hysterical disturbances associated with neurasthenic syndromes in men from forty to fifty years of age, and the milder post-climacteric depressions and agitations are not at all responsive. On the whole disorders associated with 'passive' tendencies in men and with 'active' tendencies in women are the most unsatisfactory cases to deal with.

*Secondary gain* is not so difficult to observe. The patient usually succeeds, although at a cost, in entrenching himself in a favoured or protected position relative to his family, his psycho-sexual life and his social or occupational environment. These gains are more obvious in people of middle-age and over. In adolescence the 'gain' factor is frequently expressed through delinquent anti-social conduct or by simple inhibition of working capacity. In such cases apparent self-injury covers a revenge motive directed against the parents. Such observations indicate that a distinction should be drawn between secondary gains which represent a (partly successful) attempt to establish (or maintain) a situation of infantile libidinal dependence and gains which give expression to unconscious aggressive impulses. Gains of the former type are much more easy to deal with by psychoanalysis.

Naturally both primary and secondary gains are extracted from the same set of symptoms. For example, anxiety states or obsessional outbreaks in men between 40 and 50 years of age whose hetero-sexual drives are diminishing, help to balance the relative increase in unconscious homosexual libido; this constitutes the primary gain. They also provide a situation of illness in which the individual is safe from reproaches of diminishing affection (secondary gain). Such observations explain why age factors in prognosis depend less on a hypothetical rigidity of mind than on the extent to which mental regression has been accepted by the unconscious ego. Nevertheless it is generally true that the earlier analysis is carried out the better. As in the case of certain organic diseases it is highly desirable that diagnosis should be effected if possible in childhood. Not that analysis of children is invariably successful. There is just as sharp a distinction between the prognosis of anxiety manifestations and of schizoid reactions in childhood as there is in adolescence and adult life. Despite this fact, even in the worst case, an analysis conducted in childhood is to some extent an insurance against more severe breakdown in later life.

To translate these various indications and reservations in more practical terms; it is generally desirable to divide psychological

disorders into three main groups. (a) Cases where it would be positively wrong not to recommend immediate psycho-analysis, (b) cases where the recommendation should be made only after a careful balancing of prognostic factors; and (c) cases in which a decision against immediate analysis should be given. The first group includes disorders belonging to a 'favourable' group, where the patient is obviously accessible, does not secure too much gain from his symptoms, is not too rigid in mental structure and is young enough to make fresh adaptations to life. There is, for example, no justification for withholding or delaying a recommendation of psycho-analysis in a straight-forward case of psycho-neurosis under the age of thirty. The third group includes cases where there are indications of inaccessibility, where the factors of primary and secondary gain are too strong to allow of therapeutic success, or where the patient is too old or too rigid to make fresh adaptations. In all other instances psycho-analysis should be recommended only after a careful balance has been struck between favourable and unfavourable factors. Where the issue is uncertain it is better to delay the recommendations for a period of at least three months. The contrary policy of recommending analysis in doubtful cases ends more often than not in disappointment to all concerned.

#### E. THE NATURE OF PSYCHO-ANALYTIC TREATMENT

Should the physician decide to recommend psycho-analytic treatment, he will find the patient's query - 'What *is* psycho-analysis?' by no means easy to answer. Even if he is conversant with the principles of psycho-analysis and has some understanding of their therapeutic application, it is no simple matter to convey that understanding to the patient, whose question is in any case prompted as much by anxiety as by ignorance. The best plan is to explain in the simplest language the nature of unconscious mental conflict, the fact that it gives rise to symptoms, and to follow this up with a brief indication of some of the procedures necessary for resolution of conflict.

As a rule he will find it necessary to correct the popular impression that any kind of mental investigation constitutes a psycho-analysis. In principle there are really only two varieties of psycho-therapeutic approach, viz. suggestion and psycho-analysis; and many forms of psycho-therapy, although superficially 'analytical' in tendency, depend for their therapeutic effect on the influence of suggestion. When pure suggestion is used the state of rapport existing or developing between physician and patient is exploited in order to counter the symptom-formation. No attempt is made to resolve the state of rapport. In psycho-analysis on the other hand no attempt is made to exploit the

state of rapport between patient and analyst for the purpose of symptom-resolution. On the contrary a considerable amount of energy is devoted to analysis of the patient's reactions to treatment. No specific effort is made to oppose the symptom, which is recognised as an *end-product* of unconscious conflict. On the other hand everything possible is done to promote free functioning of the mental apparatus. Only in this way can the underlying structure of the symptom be approached, and pathogenic energies be freed from symptomatic courses.

The standard technical device employed for this purpose goes by the name of 'free association', and except in the case of timorous patients, who react with a kind of superstitious anxiety to the description of technical devices, there is no harm in giving the prospective patient some outline of this method. The patient is encouraged to say everything that comes to his mind and to describe his feelings during this process. He is asked to refrain from 'censoring' anything that occurs to him and from disguising or concealing any accompanying emotions. Usually the first effect of this procedure is to release a good deal of memory and emotion, but sooner or later difficulties arise. The association rule tends to be abrogated. These difficulties constitute 'resistances' and act as indicators of conflict. It is now the task of the analyst to resolve these resistances. This he does by means of 'interpretation'. Interpretation can be either positive, when the unconscious content giving rise to the difficulty is communicated to the patient, or exploratory, when the unconscious emotions (usually anxiety and/or guilt) causing the hitch are ventilated. Interpretations are based partly on the analyst's reading of the material contributed and partly on his experience of similar cases. The interpretative process is also applied to the patient's dreams and phantasies. These are specially informative owing to the fact that in dream life unconscious drives and fears obtain more immediate expression, both directly and by the indirect means of symbol-formation than they do in waking thought.

Needless to say it is not desirable to discuss the more technical aspects of interpretation or the nature and analysis of resistances. It is sufficient to satisfy the patient's legitimate curiosity as to the general method. Any detailed description of technique is likely to interfere with the spontaneity of his subsequent analysis. Nevertheless those who have already heard of free association are likely to have heard also of the term 'transference'. They may in fact question the physician on this subject, or express some prejudices regarding it. For this reason it is desirable for the physician to be clear as to the exact significance of the term and if necessary to correct any misapprehensions or alleviate any anxieties that may exist in the patient's mind.

Although analysts do not exploit rapport to combat symptoms directly, the existence of a more or less friendly rapport helps to start



off the analysis and to overcome some preliminary resistances. Later it becomes apparent that some of the most stubborn resistances are themselves due to unconscious varieties of rapport. These are given the special name of *transferences* and are divided into positive and negative varieties in accordance with the degree of friendly or hostile reaction they express. The point about these positive and negative transferences is that they are displacements of mainly infantile reactions from unconscious (family) images to the person of the analyst. As a result of this transfer infantile attitudes and situations are brought into the open and can be analysed in a fresh state. In a typical neurosis the symptoms begin to loosen up at this stage and are replaced by the so-called *transference neurosis*. In other words when the original level of conflict is reached, the patient tends to repeat, 'act out' or dramatise in analysis the emotional situation responsible for the conflict. Needless to say the analyst remains an observer of these repetitions, eschewing any of the roles in which he is cast by the patient. His business is to exploit the transference by analysing it. *Indeed thorough analysis of this transference neurosis must be effected before symptomatic improvement can be regarded as permanent.* Once it has been achieved, warning of the approaching termination of the analysis is given. The last stage of transference analysis is then carried through under the stimulus of this approaching threat of independence.

Analysis of the transference neurosis constitutes the most difficult phase of psycho-analytic therapy. For the first time the patient is threatened with the loss of primary or secondary gain previously secured through symptom-formation. Many patients who up to this point have apparently made satisfactory progress, as judged by the disappearance of symptoms, begin to regress as soon as the transference situation they have built up is threatened. Previous symptoms may recur or new varieties may take their place. Alternatively the patient, instead of reactivating his symptoms, may begin to exhibit infantile traits of character. But whatever form the regression may take, it is essential that it should be countered by effective interpretation. The patient must be rendered capable of adapting to his conditions of life without either the infantile reservations and inhibitions represented by symptoms or the compensations of an infantile rapport with the analyst.

Of course none of these stages of analysis, viz., the introductory phase, the transference neurosis, and the final stage of ego-adaptation appears in distinct outline. All of them overlap. Moreover the existence of resistances further blurs the general form of analysis. The analyst is compelled to allow adequate intervals for the 'working through' of particular complexes, and for the resolution of early traumatic situations. Many patients tend to abandon analysis as soon as they

experience symptomatic release, and many others are compelled through extrinsic causes to give up treatment before the classical stages have been completed. Nevertheless it is true that the more fully the various phases have been experienced the more satisfactory and permanent the result will be.

The foregoing account applies only to the analysis of cases of transference neurosis (the hysterias and obsessions). In the analysis of character cases or of anti-social conduct transferences do not follow the same comparatively simple course. Usually they have an unobtrusive form or express themselves in a persistently negative (resistant) way. In such cases a preliminary step in the resolution of difficulties is the uncovering of concealed neurotic reactions. Once the latter have appeared the transference begins to conform to the usual neurotic pattern and permanent improvement or cure can be looked for. Psychotic patients frequently create the impression that the transference relation is minimal. This is a misapprehension. The inaccessibility of many psychotic types is partly a spontaneous negative transference and partly a protective regression. The trouble about psychotic transferences is that when they become active they tend to express themselves in the form of psychotic episodes. These are difficult to distinguish from periods of spontaneous regression and may sometimes lead to the premature abandonment of analysis. Nevertheless the patient should be kept under analytic observation until such time as he can resume direct analysis. It is during these difficult stages that the family physician is able to render invaluable service to the psycho-analyst. Naturally the family and friends base their estimates of analytic progress almost exclusively on symptomatic standards, and are only too ready to advise discontinuance of analysis when an exacerbation of symptoms occurs. This is a difficulty rarely experienced in organic treatment. Patients suffering from chronic physical disorders will put up cheerfully enough with frequent relapses to say nothing of the discomforts incident to radical treatment. The physician should use his influence to encourage continuance of treatment, a policy which will be amply repaid when in course of time these psychotic episodes are replaced by neurotic crises. The appearance of neurotic crises is indeed one of the most favourable signs to be observed during the psycho-analysis of psychotic cases. During the analysis of depressive cases, for example, an eruption of obsessional symptoms is a good sign and is usually followed by increased ego-stability.

A similar difficulty is encountered in the analysis of anti-social disorders. Apart from the fact that patients suffering from compulsive (obsessional) forms of delinquency are likely in any case to repeat their delinquent conduct during the earlier phases of analysis, a number of delinquent patients signalise the appearance of unconscious crises

by an acute regression in conduct. Unfortunately this is regarded by judicial authorities as a sign of perversity and usually ends in the interruption of treatment by the imposition of a prison sentence. In such cases the family physician acting in concert with the psycho-analyst should try to induce the Court to take an enlightened view of the situation.

Perhaps the best example of the difficulty is observed during the psycho-analysis of children. In such cases however the order is usually reversed. Children suffering from neurotic symptom-formations or inhibitions frequently tend to shew unaccustomed signs of negativistic conduct. This outcropping of 'bad behaviour' is naturally regarded by unoriented and over-anxious parents as a sign of deterioration due to the influence of treatment; hence they may seek to bring the analysis to a rapid or sometimes an abrupt termination. Here again the physician can greatly assist the psycho-analyst by inducing the parents to endure such difficulties as patiently as they can, assuring them that they are harbingers of progress in treatment.

A number of prospective patients although familiar with the term psycho-analysis nevertheless think it has something to do with hypnosis, or, at least, suggestion. Some of them indeed are distinctly alarmed by the idea of coming under what they imagine to be mysterious and possibly harmful influences. Others again confuse psycho-analysis with other forms of analytical psychology. Hence the physician is frequently asked: what is the difference between psycho-analysis and other forms of psycho-therapy? As has been suggested, the most fundamental distinction lies in the fact that psycho-analysts are concerned to uncover, analyse and resolve infantile transferences. But the existence of this fundamental difference does not imply that psycho-analysis is the only method of treatment whereby 'cures' can be effected: nor should any suggestion of this kind be made to the patient. On the contrary he should be informed not only that any form of psycho-therapy can be depended on to produce a number of cures, but that spontaneous remission of psychological disorders also occurs. Even the simple procedure of taking a good case history can have at times surprisingly good therapeutic effect. This can be enhanced by adopting some form of association technique. Or, using both history-taking and association methods, a frontal attack can be made on the symptom. Interpretation of this material can be given and can be reinforced through persuasion, exhortation, declamation or some other variety of suggestion. But even in the absence of open suggestive procedure, such interpretative approach does not constitute a psycho-analysis. There are, of course, other ways of distinguishing between psycho-analysis and other forms of therapy, e.g. the content of interpretations, the nature of etiological views, the correction of unconscious mechanisms and the analysis of

unconscious ego structure. But unless the patient has read of controversies between different psychological schools and asks for enlightenment there is no point in going into such details. Nor is it advisable, as a rule, to attempt any descriptions of transference situations or analysis. It should be emphasised that symptoms, whether expressed by disturbances of thought, feeling, action or bodily function, constitute a distorted 'language' giving outlet to conflict in a disguised but often symbolical way that is not only ill-adapted but positively detrimental to the reality interests of the ego. These points can be illustrated by a few simple examples. Attempts to describe the technique of analysis should be avoided, and in any case do not convey much to persons who are not already orientated on the subject. A brief explanation of the nature and effect of 'free association', together with a description of the conditions under which it is carried out, are usually sufficient to give the prospective patient some idea of what may be expected of him. It will also prepare him to face the fact that psycho-analysis is of necessity a lengthy process.

#### F. THE DURATION OF TREATMENT

It is important for both practitioner and patient to be thoroughly acquainted with the time factor in psycho-analysis, and this not merely for practical reasons. Preliminary resistances to analysis very often seize on and magnify the importance of this factor. In the case of chronic organic disease the physician neither feels disposed, nor is called on, to apologise for the duration of any treatment that may be indicated. A moment's reflection will show that it is absurd to expect a deep neurosis of several years' standing to be capable of analytic resolution in a few weeks or by attending once or twice a week. It is true that many symptoms can be considerably alleviated in a few weeks. Some may even disappear after one consultation. This may be due to a sudden relief from marginal anxiety, but more usually it is a 'transference' phenomenon and lasts only so long as the unconscious rapport with the imago of the physician persists. Considerable disappointment can be saved the average patient if it is made clear from the outset that radical alteration of mental structure or fixation must of necessity be slow. It is a much better policy to give conservative estimates and to avoid the temptation to reassure the patient by promising rapid cure. The length of time necessary depends on the age of the patient, the clinical type of disease (in particular its chronicity, severity and depth), the patient's 'pre-analytic resistances' and his unconscious gain from illness. But there is no exact ratio between these factors and the length of treatment. Apparently severe attacks sometimes readjust rapidly;

on the other hand an apparently simple monosymptomatic neurosis, e.g. a mild phobia, may involve a prolonged exploration of the very wide area of unconscious organisation on which it may be based.

The reason for these apparent discrepancies is not hard to find. As has been emphasised in the theoretical section, the efficiency of the mental apparatus can be estimated accurately only provided the total function of mind is observed. This applies alike to so-called normal persons and to those suffering from manifest mental disorder. The casting of what might be called *functional balance sheets* is therefore an essential part of psychological practice. Although symptom-formations are the result of unconscious conflict and may damage severely the patient's capacity for adaptation, nevertheless up to a point the symptom itself plays a part in maintaining mental balance. The point at which it fails to do so is usually determined by the patient or by his family and friends. Either the discomfort and inhibition produced are too painful or too crippling to be endured any longer by the patient, or his family and friends are no longer able to endure the inconveniences caused to them or the emotional upset or disapproval induced in them by the patient's symptoms. In the one case the patient seeks advice; in the other he is goaded into seeking advice by the family who commonly enough make a point also of choosing the person to be consulted.

But apart from the question of total balance of function, considerable variations exist in the mental 'reserves' of the patient. The capacity to endure stress varies considerably. Hence patients whose reserves are nearing exhaustion but not completely exhausted may from time to time exhibit symptoms of a dramatic character which nevertheless disappear rapidly at the commencement of treatment. Even when the margin of safety has disappeared, it does not follow that the patient will immediately develop symptoms of a dramatic nature. These differences account for the sometimes puzzling variations in reaction to treatment. They can be conveniently studied in so-called 'normal' persons. Many apparently well-balanced individuals maintain their mental balance by exercising a number of mild symptomatic habits. The person who is faddy about food and makes a practice of secretly polishing the cutlery on the folds of the table cloth is a case in point. It is easy to observe that when he is undergoing any unusual stress these habits increase in frequency and are practised quite openly.

Variations are however the exceptions that prove the rule. In fact it is usually possible to give a roughly accurate estimate of duration. In the average case of anxiety hysteria rapid symptomatic improvement can be observed within the first six months, followed by a slower and more difficult phase in which improvement alternates with regression. Sometimes, on the other hand, the opening phase is difficult but is followed by slow improvement which reaches its maximum in the

terminal phases. Even if symptomatic improvement is rapid, this does not determine the length of the analysis, which must be thorough enough to prevent relapse. Hence, even in simple phobias it is well to warn the patient that his difficulties may take two years to eradicate. Similar estimates can be given in the case of conversion hysteria. Caution should be exercised where there is an organic 'fixation' element (previous or concurrent organic disease in the organs psychologically involved). Somatic manifestations of anxiety and some neurasthenic manifestations may clear up quite suddenly, but this of itself is no guarantee of a short analysis. Obsessional cases are difficult and usually lengthy. On rare occasions a complicated obsessional system may clear up superficially in a few months but ideally the analysis of obsessional cases should not be less than two and a half years in duration. It may have to be continued for four to five years. In psychotic cases no time estimates should be given. Depressive symptoms may exhibit comparatively rapid remissions, but this depends to some extent on the phase of the cycle at which analysis has commenced. It is no criterion of ultimate success. Mild sexual inhibitions often clear up within the first six months. Mild social inhibitions are also readily amenable to analysis, but take longer to improve than sexual inhibitions. In the case of mild sexual perversions, sanguine estimates should be avoided. The underlying structure is frequently hard to resolve, and a conservative estimate should be given, i.e. a minimum of two years. Mild delinquency cases of the hysterical type may clear up within a year: obsessional types require much longer. In the case of severe sexual perversions and the more outstanding character difficulties no immediate estimates of duration should be offered. As with the psychoses, accurate estimates cannot be made until the preliminary stage of analysis has been completed, usually at the end of six weeks. This policy of giving a delayed estimate of duration should be distinguished from that of the probationary analysis or *trial trip*, i.e. recommending a few weeks analysis with a view to completing diagnosis and estimating accessibility to treatment. Incidentally the practice of making *probationary analyses*, although apparently a sensible one, is not to be encouraged. This is borne out by the fact that few probationary analyses end in a recommendation to discontinue treatment. In doubtful cases it is better to counsel delay and to re-examine the patient at suitable intervals.

To sum up, estimates of duration should generally be based on the physician's impression of the total function of the patient's mind, the strength of his instincts, the stability of his ego and the strength or weakness of his mental defence mechanisms—not on the apparent strength of his symptom constructions. The proper recommendation for patients whose time is limited, for reasons beyond their control, depends on the nature of the case. Should there be reasonable expecta-

tion of major alleviation of symptoms or cure within the time available, or, better still, if there is a margin left over in which additional consolidation of the ego can be secured, the practitioner is justified in recommending psycho-analysis. Should only a few months be available, it should be explained that satisfactory analysis is not possible, that symptom improvement is a gamble and that some short cut method of treatment should be considered.

### G. THE COST OF PSYCHO-ANALYSIS

One of the main obstacles to arranging an adequate period of analysis is financial. Psycho-analysis involves attendance at the analyst's consulting room for a minimum of five sessions per week, during an 'analytic year' of at least 40 weeks, i.e. a minimum of two hundred sessions per annum. It is therefore easy to calculate the total sum involved for any given or recommended period of analysis. Fees are usually paid monthly, or by special arrangement, weekly.

At first sight the prospect appears intimidating, and many patients arrive hastily at the conclusion that analysis is beyond their means. The proper way of overcoming all such difficulties is to ascertain what annual sum the prospective patient can set aside, preferably from income. From this figure it is easy to calculate what fee the patient can afford per session *without causing undue strain*. If this sum is not large enough to secure private treatment the patient should be recommended in the first instance, to any clinic where psycho-analysis is conducted by properly trained practitioners. Should the patient be anxious to avoid possible delay in securing a suitable clinic vacancy and be ready to set aside a fixed sum from capital resources, an accurate estimate should be made of the length of analysis necessary, and a private fee should be arranged that will cover this period, allowing an ample margin for eventualities. Some patients with a limited sum at their disposal are inclined to gamble on the chance of improvement within the time available and are ready to pay unmodified fees so long as their resources last, hoping that something may turn up if treatment is still incomplete when their resources are exhausted. This practice cannot be too strongly deprecated. Neither the family physician nor the psycho-analyst consulted should encourage such gambles. *Total* fees should be calculated on the *existing* capacity to pay.

Wherever possible the fees should be paid by the patient from his own resources. Even in the case of married persons this course is desirable. Naturally it is not possible in the case of most minors, and of adults who for one reason or another are unable to earn or debarred from earning their own living. Where analytic fees are paid by a friend,

the sum advanced should be regarded by the patient as a loan to be repaid if and when circumstances permit. By adopting this policy the patient is made to feel that he is fully responsible for his own analysis and an additional incentive is provided to bring it to as rapid a termination as is possible or desirable. Similar incentives are provided by a number of other extrinsic circumstances, e.g., conditions of work, residence or time available. But although some resistances are curtailed in this way others may be mobilised, and on the whole, the situation is an unsatisfactory one. The patients who respond most favourably to these restrictions are of an anxiety type; more intractable cases do not respond, and masochistic types are unconsciously tempted to exploit these hardships; knowing that time or money is limited they strive unconsciously to 'play out time' with the result that, despite some preliminary improvement, the analysis ends in stalemate.

Finally it is to be noted that the factor of cost provokes resistance not only in the patient but in the minds of both practitioners and general public who are inclined to regard psycho-analysis as purely a luxury treatment and, not to put too fine a point on it, to describe psychoanalysts as gold-diggers. As a matter of fact the situation differs in only one respect from that existing in the case of specialized treatment of any chronic organic disorders, viz., that there is an acute shortage of trained psycho-analysts. Psycho-analysis is always an arduous occupation and frequently a thankless pursuit. On the average, psychoanalysts earn much smaller incomes than most other mental specialists, not to speak of specialists in organic disease. Like all other specialists they devote a fair part of their time to non-paying cases and a still more substantial part to cases paying modified fees. More cannot humanly be expected of them. Incidentally the practice of taking cases without any sort of payment is not a satisfactory one. It creates a situation of infantile dependence for the patient and therefore complicates the transference situation unduly. Even in clinic practice it is desirable for the patient to make some payment however small it may be. If he can afford only sixpence a week, his weekly fee should be fixed at sixpence. On the other hand no patient should be asked to pay more than he can reasonably afford. The word reasonable can legitimately be held to connote some degree of sacrifice or inconvenience, but not more than is expected of any patient, whose illness is in any case a hardship.

#### H. THE CHOICE OF PSYCHO-ANALYST

In the existing stage of development of mental science, the psychoanalyst may fairly be described as a maid-of-all-work. True he must undergo a lengthy and complicated training and to that extent is a



specialist in the best sense of the term. But if we compare his position with that of the organic specialist one outstanding difference can be observed. The psycho-analyst of to-day is essentially a 'general practitioner', that is to say, he is called on to diagnose and treat every variety of mental disease. With the expansion of psychological research and a proportionate increase in the number of qualified workers, we may anticipate a radical change in this state of affairs. Already the practice of child-analysis is regarded as a special branch of psycho-analysis: and in some countries psycho-analysis is practised for the most part by psychiatrists whose primary interest is focused on the psychoses. There is no doubt that in course of time there will be as many varieties of psycho-analytical specialist as there are at present varieties of organic specialist. The former will of course pass through the same general psycho-analytical training but will thereafter concentrate their attention on special groups of disorders: e.g. the neuroses, the psychoses, character and social disorders, sexual disorders and so forth. No doubt also special modifications of psycho-analytic technique will be developed to meet the necessities of different disorders. It is already apparent that treatment of the psychoses and of some delinquent disorders calls for an elasticity in technique that is undesirable in the treatment of neuroses. This does not mean that the fundamental principles of psycho-analysis will change, merely that their therapeutic application will have to be adjusted to the clinical difficulties peculiar to any given disorder.

In the meantime the general practitioner faced with the necessity of recommending his patient to a particular analyst may find himself in a quandary, and unless he has other and more direct means of arriving at a decision he can but fall back on the professional criterion applicable to all specialists irrespective of their branch of study. If he desires his patient to undergo a psycho-analysis, he must ascertain that the analyst he recommends should have undergone a recognised course in training in Freudian principles and practice. *For the term psycho-analyst by professional consent is applicable only to those who have undergone strictly Freudian training.* This distinction is the more important since in recent times some forms of psycho-analytic training in this country include the inculcation of 'new' theories which are strictly speaking 'deviations' from Freudian theory. If the physician is in doubt on the point he should not hesitate to make point-blank enquiries of the analyst himself.

Naturally the difficulty is lessened when a recommendation at second-hand can be secured from some fellow-practitioner. It should however be borne in mind that as in organic medicine the prestige of a specialist is not an entirely dependable measure of his competence. The presence of grey hairs is no guarantee of psychological acumen; yet, such are

the irrational laws of prestige-formation, it is almost impossible for a junior of mediocre attainments to pass the middle-age mark without developing a reputation for professional maturity also. In short the best course available to those who are uncertain about recommendations is to make personal contact with the analyst they have in mind. Admittedly they will not be able to judge of the quality of his training, but they will be able not only to ascertain whether he has in fact been trained but also to make true assessments of his natural capabilities, character and commonsense.

Assuming, however, that the practitioner is in the advantageous position of being able to pick and choose between a number of psychoanalysts, the question arises whether he can determine his ultimate choice in accordance with the necessities of his patient. This depends on two factors, first, his knowledge of clinical variations in temperament and constitution occurring in different types of patient and, second, his familiarity with the different character types that choose psycho-analysis as a profession. As it happens psycho-analysis has not yet arrived at that state of general recognition when it is pursued for purely careerist motives. And so far only a minority of psychoanalysts turn to it because of their lack of success in other branches of medicine. Inevitably therefore it is pursued by persons who are either attracted by problems of mental disorder or have a powerful urge to cure or alleviate mental suffering.

The first of these groups can be sub-divided in a number of ways. Naturally a considerable number are attracted because of their own experiences of mental conflict. This of course is not peculiar to the practice of psycho-analysis: it applies to every branch of psychotherapy and to most branches of psychology. Hence no doubt the popular belief that medical psychology is a field of endeavour set apart for the activities of cranks. Actually no precise investigations have been made on this point and on the whole it is probable that the percentage of 'peculiar' people adopting medical psychology as a profession is only slightly higher than that obtaining in other and more conventional branches of medicine. No doubt if parallel investigations were made of the motives for selecting psycho-therapy, surgery and gynaecology as professions, the results would be chastening to the critics of psycho-analysis.

In any case there is something to be said for the view that previous personal experience of mental conflict is not a drawback to the practitioner of psycho-analysis, provided always, and the proviso is a strict one, the personal psycho-analysis he undergoes as an obligatory part of his training has reduced any psychological symptoms from which he may suffer to the point at which they do not interfere with the efficiency of his technique. The argument about 'neurotic analysts'

cuts both ways. For whereas the persistence of active mental conflict may produce a blind spot for the defences thrown up by patients having similar difficulties there is no doubt that once this conflict has been resolved, the practitioner not only retains a profound understanding of difficulties similar to those from which he himself has suffered but is unusually familiar with the patient's techniques of defence. The real drawback is that, for example, whereas an obsessional type of analyst may be unusually successful with obsessional cases, and to a lesser extent with cases of hysteria, he is not likely to have an intuitive understanding of the mentality of a depressive case. This however is only another argument in favour of specialism in psycho-analysis.

Apart from those who are attracted to psycho-analysis because of their own personal experiences of conflict, a number are attracted because of their interest in special types of disorder. Thus the psychiatric psycho-analyst is usually a psychiatrist first and a psycho-analyst second. And this interest in the more dramatic forms of mental disintegration is not likely to conduce to an understanding of the more complex forms, or perhaps it would be better to say, the finer shades of personal conflict. Others again are interested in the protean manifestations of human anxiety and still others in the innumerable derivatives of unconscious guilt, or in the mechanisms of depression or in the narcissistic defences of the schizophrenic.

Of the second group, whose members are interested primarily in the alleviation of mental suffering, the same sub-divisions can be effected. They are however of secondary significance. The interests of members of this group are up to a point selective but not so markedly so as to limit their capacity to deal with an all-round analytic practice. The main handicap from which they suffer is a lack of prognostic perspective. They are more likely to recommend analysis on diagnostic grounds and to pursue it on the face of heavy odds. This is sometimes a good fault, but on occasion it can lead to a failure to recognise the limitations present in any given case or to the pursuit of a lengthy analysis that is not justified by results.

Apart from variations due to deep personal factors, psycho-analysts vary also a good deal in their cultural background and approach as well as in their experience of life. Theoretically regarded these variations should not prevent a competently trained analyst from carrying through a competent analysis. And indeed there are many competent analysts whose cultural *milieu* and background are below rather than above average professional standards. They are little more than psycho-analytical therapists; or, to put it at the best, trained healers rather than artists in human relations. And it cannot be denied that their professional capacities would have been greatly reinforced had they been founded on a broad cultural education and experience. But

perhaps the capacity to be most sought after in a psycho-analyst is that of judgement – in any case a rare quality. Good clinical judgement, good judgement of human nature, a sense of mental movement, a flair for detecting emotional crises, an understanding of difficulties and not a little commonsense are attributes which, disciplined and directed by adequate training, go to make up the 'ideal' analyst.

Such paragons of perfection are naturally extremely rare, rarer even than masters of surgery or medicine; and perhaps the best the physician can do in the matter of selection is to make sure that the psycho-analyst has had a proper Freudian training, has no hare-brained theories of his own manufacture, and that he had special qualifications of disposition and experience suitable to the nature of the case. Other things being equal an analyst with a broad experience of psychiatric work will be more at home and more capable of dealing with psychotic crises than others not so experienced. Disturbances and inhibitions of social and sublimatory function or of emotional expression should on the other hand be sent to analysts of a less specialised type and preferably to those whose cultural background at least matches that of the patient. For while it may be true that any trained analyst should be able to analyse any case there is no reason why personality factors should not influence the choice of analyst. At the least this course is likely to make the patient feel more at home in the earlier and more sensitive stages of the analysis.

Similar considerations apply to the problem of the *sex of the analyst*. Here again there is in theory no reason why any analyst should not analyse any case. And the nature of infantile transference is such that, for example, both father and mother transferences occur irrespective of the sex of the analyst, a state of affairs which in any case is fostered by the innate bisexuality of both analyst and patient. On the other hand, there is no doubt that the *order of emergence* of unconscious psychic situations during the earlier stages of analysis varies in accordance with the sex of the analyst; also that the freedom of expression of negative transferences is to some extent affected by it. Many intriguing problems arise in this connection, which however are difficult to resolve without the co-operation of the psycho-analyst himself. In any case the wishes and preferences of the patient should not be ignored. For although these are frequently motivated by unconscious prejudices, and although in the long run the patient does not really spare himself conflict by choosing a male in preference to a female analyst, or vice-versa, there is in most cases no reason why the early stages of analysis should be made more difficult than they are or the early attitudes of the patient more resistant than they need be.

In some countries, including Britain, the training of *lay-analysts* is officially sanctioned if not perhaps encouraged; and since there is always a shortage of medically qualified analysts the physician is occasionally perturbed to find that only a lay-analyst may be available. This perturbation is due largely to the traditional prejudice of the medically qualified against non-medical practitioners, also to the feeling that nurses, psychiatric social workers and other technical assistants are of lower professional status than doctors. Even when they are ready to accept the assurance that lay-analysts undergo a Freudian training and are vouched for by their medically qualified colleagues, many doctors are still uncertain as to the type of case that can properly be sent to lay-analysts.

The propriety of training lay-analysts is a matter concerning which wide differences of opinion exist amongst analysts themselves. On the one hand it is argued, particularly by lay-analysts, that since hospital teaching does not include any psychological instruction worthy of the name, and since absorption in the problems of organic pathology may blunt rather than sharpen psychological perception, there is no advantage and possibly some disadvantage in undergoing medical training. It is further argued that as the majority of psychological disorders treated by psycho-analysts are not even remotely connected with or complicated by organic dysfunction, there is in such cases no need at all to insist on medical training. And if we overlook for the moment the fact that even formal psychiatric training is confined to medical students, there is something to be said for these views.

On the other hand, there are a number of equally cogent considerations in favour of limiting the practice of psycho-analysis to fully trained medical practitioners; in particular that the clinical disciplines acquired in medical schools and hospitals provide not only that training in scientific method which most lay persons lack, but an understanding of functional balance which conduces to good psychological practice; that knowledge of organic disease is essential to the differential diagnosis and treatment of those psychological disorders which are expressed either wholly or partly in somatic manifestations; that adequate training in formal psychiatry can be obtained only by registered medical students; and that any condition associated with risk to life must be exclusively the concern of a qualified medical attendant.

The main justification for sanctioning lay-analysis is simply that as there is an acute shortage of medical analysts it is undesirable to exclude from practice lay persons whose psycho-therapeutic gifts are outstanding, provided of course they have undergone a strict psycho-analytical training. No doubt in course of time the practice of medical psychology will be limited to those who are medically qualified but in the meantime no physician need have any misgivings about entrusting

to qualified lay-analysts the psycho-analysis of uncomplicated transference neuroses, (conversion hysterias always excepted) inhibitions and perversions, and character difficulties of a non-psychotic type. The psycho-analysis of children is frequently delegated to lay-analysts, a practice incidentally which has been followed by child guidance clinics where so-called 'play therapy', conducted by non-medical persons under supervision, is generally recognised. Nevertheless child psychiatry as such remains and will continue to be a medical speciality. Finally it should be noted that lay-analysts are debarred from diagnostic work and are not permitted to accept cases for psycho-analysis that have not been examined by a medical analyst, who remains professionally responsible for any treatment that may be carried out by a lay colleague.

## J. THE FAMILY SITUATION

As a rule, once the patient has embarked on analysis, the role of the practitioner should be a purely expectant one. There are times, however, when he can be of considerable assistance to the psycho-analyst by helping to keep the peace within the family. On many occasions both relatives and friends are openly suspicious of or hostile to psycho-analysis. Even when their conscious attitude is genuinely co-operative, they may unconsciously resent or be jealous of the situation, and, quite unwittingly, do everything they can to obstruct it. This attitude is most frequently observed during the analysis of children. The possessive mother, for example, who unconsciously realises that her child's neurosis makes him or her more dependent on maternal support, may at the same time complain of the child's troublesomeness and obstruct every effort to deal with it by analysis. Reactions of this sort are all the more likely when, as is sometimes the case during analysis, the opening up of hidden conflict makes the patient behave for the time being in a more trying way than usual. Similar reactions are to be observed during the analysis of adults.

Moreover there are occasions when, despite the discomfort of having a neurotic individual in their midst, the family may unconsciously tolerate the crippling of, for example, some unusually talented member. It should be remembered that although some neurotics use their illnesses as a mask for real incapacity, others, particularly obsessional and paranoid cases, are persons of superior intellect. Their falling ill may provide a 'secondary gain' to those of the family who are consciously or unconsciously jealous of them. Unconscious jealousy is usually concealed by an over-solicitous reaction; the family may for example, insist that the analysis should be broken off lest the patient should be 'driven mad' or 'become irresponsible'.

Again where the patient has sought help on account of marital difficulties, the attitude of the husband, or wife as the case may be, is likely to be extremely ambivalent. At the first sign of increased friction, and periodic increases of marital friction however transient are frequently associated with the exploration of infantile complexes, the marriage partner becomes openly hostile and does everything he or she can to bring the analysis to a termination. A similar situation may develop when treatment is embarked on without any personal conviction but on the urgent recommendation of some friend who has an enthusiastic interest in psycho-analysis. In this case however the patient has little personal incentive to cling to analysis in face of family opposition and is easily prevailed upon to abandon the project.

Now the psycho-analyst is at a great disadvantage in dealing with this situation. Psycho-analysis is subject to the most stringent of all codes of professional discretion. Except in the case of minors and defectives, contact with relatives and friends is expressly avoided. Only with the direct approval of the patient may family interviews take place and then only on the understanding that all matters discussed during the interview will be communicated to the patient. This may seem an unconscionable practice but it is essential to the conduct of a free analysis. At the risk of incurring the displeasure of the family, the analyst must refuse all family interviews that are not sanctioned by the patient. He is therefore unable to deal personally with any family crises that may develop. The family practitioner on the other hand, can smooth over many of these difficulties and, in the last resort, should act as a buffer between the family and the psycho-analyst. In so doing he may be sure that he is advancing the patient's interests. These situations demand the exercise of considerable tact. As in the case of psychological examinations, it is undesirable to adopt any attitude that might be regarded as coercive. Should the practitioner himself be in doubt either about the progress of the case or as to the best way of handling the family situation he should not hesitate at any time to raise such matters with the analyst.

#### K. RESULTS OF TREATMENT.

During their more active phases of resistance it is not uncommon for patients to comment on the fact that they have never come across anyone who has been 'cured' by psycho-analysis and to express their desire to meet such a *rara avis*. This form of resistance is not confined to patients. It is shared, naturally enough, by many psycho-therapeutic colleagues, particularly by psychiatrists who have smarted under the suggestion that non-analytical methods are psychologically obscurantist.

To a certain extent psycho-analysts are themselves to blame for this form of professional criticism. Partly for subjective reasons and partly because many of them have in the past reacted to persistent animadversion by adopting an attitude of superiority or condescension to non-analytical colleagues, psycho-analysts have created the impression that they regard other methods of mental treatment as somehow inferior. Reactions of this sort are of course both unprofessional and absurd. It is possible for a psycho-analyst to maintain that Freudian theory is the only valid clinical theory: but it would be ridiculous to suggest that non-analytical practice should be judged otherwise than on its therapeutic merits. As far as general practitioners are concerned it is probably accurate to say that their prejudices against psycho-analysis and their scepticisms regarding results of treatment do not differ much from those expressed by the public at large. No doubt these attitudes are reinforced by the professional conviction that *all* somatic symptoms *must* somehow or other be due to organic causes, implying thereby that psycho-therapeutic treatment of *any* somatic symptom is futile.

On the other hand there is no doubt that psycho-therapists of *all* schools are unduly coy about their results. Like most physicians they are naturally elated by their successes and inclined to preserve a discreet silence about their failures; or, should the matter be raised, to point out in extenuation of failure that although the patients symptoms did not disappear his general health and working capacity were greatly benefited. However natural these defensive attitudes may be, there is not a shred of scientific justification for them. Provided his technical training is sound and provided he selects his cases with due regard to their suitability, the psycho-analyst has no real reason to fear comparison of psycho-analysis with any other form of psycho-therapeutic technique. The fact that treatment is lengthy should induce no more guilt in him than does the protracted treatment of chronic organic disease in the mind of the organic physician. Should however, the psycho-analyst extend the application of his technique to cases other than transference neuroses, simple sexual inhibitions and mild character difficulties, the mere importunity of his patients will sooner or later compel him to adopt this course, he should be prepared to face failure in a higher proportion of cases. He should however, prepare such patients for the possibility of failure. Moreover there is no reason in the world why he should not seek to alleviate the sufferings of those older and, strictly speaking, less suitable patients whose gain from illness is likely to prejudice their complete recovery. One can easily imagine to what an absurd impasse organic therapy would be reduced if the organic physician were constantly reproached with his failure to keep all his patients alive, or debarred from treating them because he could promise no more than an alleviation of their symptoms.



It is perhaps not altogether superfluous to add that in all forms of psycho-therapy as in all forms of organic therapy results should be corrected for the factor of spontaneous recovery. The healing of mental wounds differs from the healing of organic disorders in only one respect namely, that in the former case the factor of spontaneous transference is a constant therapeutic aid. Not only do many cases of severe mental breakdown recover without any formal therapeutic help, but practically any form of psycho-therapy is capable of producing its quota of 'cures'. In other words it is sometimes impossible to prevent patients curing themselves. It behoves the therapist therefore to exercise a becoming modesty about his 'results', and to apply to them the most rigid of statistical disciplines.

## APPENDIX

## MODIFICATIONS OF PSYCHO-ANALYTICAL THERAPY

Although Freud never abated his insistence on the validity of psycho-analytic theory, he was ready to concede that a therapeutic method so lengthy as psycho-analysis and involving such a prolonged course of technical training on the part of its practitioners was not suitable to meet a mass demand for psycho-therapy. Writing on this subject at the height of his career Freud, visualised a time when to meet this demand analytic methods might be combined with procedures such as hypnosis and suggestion. He was careful, however, to point out that these combined methods would not constitute a true psycho-analysis. Some years later, reviewing the progress of analytic therapy and in particular methods of terminating analysis, he bluntly stated that the best way to shorten an analysis was to carry it out correctly.

The advent of a Second World War followed as it was by a spectacular expansion of 'psychiatric' services revived interest in the possibility of shortening psycho-analysis. All sorts of 'short-cut' methods of psycho-therapy were practised under service conditions, and inevitably attempts were made both by psycho-analysts and by non-analytical therapists to combine an analytical approach with other methods, e.g., hypnosis, induction of narcosis and the like. Just as inevitably some of the hardy misconceptions regarding psycho-analysis have gained a new lease of life thereby. It is therefore desirable to reiterate the fundamental differences between classical psycho-analysis and *all* other psycho-therapeutic methods, and to indicate the nature and scope of so-called 'modifications' of psycho-analysis.

As has been emphasised throughout the foregoing presentation the essential difference between psycho-analysis proper and other therapeutic methods lies in the fact that during analysis no attempt is made to influence the patient other than by interpretation of unconscious content and by analysis of the transferences that develop between analyst and patient (the transference-neurosis). This permits a clear distinction to be drawn between psycho-analysis and methods of suggestion or hypnosis, also between psycho-analysis and the techniques developed by Jung, Adler, Stekel, Rank, Horney and other less known clinical psychologists. Using these criteria the position of the 'eclectic' is also easy to define. Combining widely different and often incompatible interpretations of mental function and disorder, with varying amounts of persuasion, exhortation or indirect suggestion eclectic methods depend ultimately on the effect of unanalysed trans-

ferences. Not that the effect of an unanalysed transference is to be despised. On the contrary the patient who is denied psycho-therapeutic treatment proceeds automatically to treat himself by transferences, that is to say, he exploits his familial and social contacts in an infantile manner in order to alleviate his mental or physical distress. Spontaneous cures of this sort are a commonplace of psychological observation. It is only to be expected therefore that skilled application of non-analytical methods should in suitable cases result in 'cures' of varying duration. As has been pointed out even a single consultation will on occasion produce quite striking therapeutic results.

The issue between psycho-analysis and other forms of psycho-therapy does not turn solely on the results of treatment. It is a common experience of psycho-analysts to be consulted by patients who have undergone every other form of psycho-therapy. And no doubt general psycho-therapists could quote many cases where after an unsuccessful psycho-analysis the patient has had recourse to non-analytical methods. Certainly both analytical and non-analytical therapists could report cases to spare in which *every* method of treatment has failed; though doubtless the number of such cases would be greatly reduced if more careful prognoses were effected and more suitable recommendations made. The psycho-analyst stands by his technique on the following grounds, viz., that psycho-analysis is the most radical of all methods of treatment, that analysis of the transference leads to the most permanent results, that alleviation or 'cure' of symptoms unsupported by analysis of the total personality is a lop-sided and haphazard procedure and that incorrect or superficial interpretations owe whatever beneficial effect they may produce to the existence of unresolved positive transferences.

All this notwithstanding, many psycho-analysts still pre-occupy themselves with methods of shortening analysis. Some direct their energies to the discovery of still more effective interpretations and to the technique whereby these may be more effectively delivered, i.e., to problems of timing, dosage, transference and resistance. Others however, seduced by the attractions of the short cut, have tried to find whether existing psycho-analytical knowledge can be more effectively applied with the help of artificial devices. Classification of modifications of psycho-analysis depends therefore on whether new forms of *interpretation* are applied, or whether special forms of *transference* situation are exploited or again whether *artificial* devices are adopted in order to overcome *resistances*.

*Modifications of Interpretation.* Strictly speaking only those modifications are psycho-analytically valid that are based on clinical observation and are also adequately corroborated. Freud's early views on the importance of the Oedipus conflict in adult neuroses was for example,

subsequently corroborated by direct analysis of five-year-old children. But since the most radical psycho-analytic interpretations refer to early phases of infantile development, the psycho-analyst is faced with an apparently insurmountable obstacle, namely that during the first, and, developmentally regarded, most important years of life, a true 'psycho-analytical situation' cannot develop. If therefore he modifies his interpretations of the deepest layers he does so on the basis of *hypothetical reconstructions* of infantile life which are incapable of direct verification. At best these can acquire some degree of plausibility; at worst they can totally mislead the observer and result in the delivery of interpretations which are totally incorrect and therefore must depend for their therapeutic effect (if any) on the state of the patient's transferences. *Therapeutically regarded an inexact interpretation does not differ from any witting form of suggestion.*

In the nature of things practitioners of child-analysis more than any other are tempted to indulge in hypothetical reconstructions; and in fact most modifications of or deviations from Freudian interpretation in recent years have been advanced by child analysts or their pupils. In this country acute controversy has recently arisen over a number of these modifications and although they have received a certain amount of support by isolated groups of analysts, the standard Freudian views of child development have not been shaken. In course of time deviations from Freudian theory are likely to occur more frequently in psycho-analytical circles and it will be increasingly necessary for the practitioner, before recommending his patient to a psycho-analyst, to ascertain whether or not the latter has had a strictly Freudian training.

*Exploitations of Transference.* The most familiar forms of transference exploitation are the so-called '*short*' analysis and *group-analysis*. The former method consists in applying psycho-analytical explanations and interpretations to the symptoms described and life-history related by the patient. The number of sessions varies from about six (either consecutively or spaced over three weeks) to about sixty (distributed over five to six months). In the shorter types there is obviously little time to deal with transferences, and even in the more prolonged '*short*' analysis there is seldom more than a superficial reference to either positive or negative states of rapport. Either therefore the transference neurosis has no time to develop or when it does develop it is left unanalysed. Hence the quicker the therapeutic result is obtained the better. If there is no symptomatic modification within six sessions, the case will probably require some months more. Even so, '*short*' analysis may end in failure, in which case the analyst is compelled to fall back on psycho-analysis proper, which however is by this time considerably prejudiced by the tendentious handling occurring during the '*short*'

analysis. Although many striking and gratifying 'cures' can be secured by 'short' analysis, it should be carried out only by exceptionally experienced analysts and only when, owing to extrinsic causes, the patient is unable to carry out a proper psycho-analysis.

*Group-analysis* has come into prominence since the second World War. It is however an old method which until recently has been consistently regarded by orthodox analysts as a transference therapy and therefore not strictly speaking analysis at all. It is distinguished from ordinary group-therapy by the fact that the leader of the group is psycho-analytically trained: in non-analytical group-therapy any type of therapist will serve. Small groups averaging about twelve are selected on grounds of suitability and are encouraged to express their thoughts and feelings or discuss problems which are then made the subject of common comment or contribution. The leader may openly lead and interpret or merely hold a watching brief. In so far as *ad hoc* analytical interpretations are given the method has some resemblances to 'short' analysis, but the essence of the technique lies in the modification of the transference situation. In analysis proper a 'group of two' is constituted and all human relations including that existing between analyst and patient (transference), are expressed by verbal, or, in the case of small children, play communication. The cathartic or inhibiting effect of disclosure of preconscious emotional material in company of a number of other persons induces a more direct experience, of e.g., social anxiety, guilt, or social cohesion. Group-analysis is therefore very similar in nature to 'active' therapy in which the patient is encouraged to activate his conflicts by different forms of actual frustration or gratification. Except that group-analysis is conducted by an analyst, it has no other relation to psycho-analysis. The curative effects obtained, and it should be remembered that cures can be obtained by any form of psycho-therapy whether organised or spontaneous, are the result of the transferences developed and of the spread of identifications that occurs between the participants. Group-therapy in general has acquired considerable popularity recently, partly because of a passing craze for group methods, partly because of the need for a rapid turnover of cases but mostly because it offers an escape for the arduous and conflict-inducing labours of psycho-analysis proper. There is no harm in recommending it in cases which might benefit equally well from short analysis or when psycho-analysis is not practicable. The factor of suitability obviously limits its application. Negativistic types in particular must be excluded because of their effect on group-cohesion.

*Techniques of Resistance Reduction.* Freud's abandonment of hypnotic techniques in favour of purely psycho-analytical methods was deter-

mined not simply by the clinical fact that many patients are refractory to hypnosis and therefore to suggestion but by the discovery that the repression barrier in refractory cases could be overcome only by the application of interpretative techniques under spontaneous conditions of transference-formation. Nevertheless, as has been pointed out, Freud anticipated a time when, in order to deal with large numbers of cases, hypnotic or suggestion techniques might be used as an auxiliary device in a shortened 'analysis'. Apparently this time has now arrived. Under the labels of *hypno-analysis* and *narco-analysis* a number of so-called analytical techniques have been elaborated, the main aim of which is ostensibly to help overcome unconscious resistances to analysis. In *hypno-analysis* various degrees of trance are induced during which attempts are made to explore emotional resistances whose existence is suspected on *a priori* analytical grounds. Between periods of trance-induction the patient carries out a formal 'analysis' during which the analyst is guided by observations made during trance-therapy, i.e., the analysis is not strictly speaking 'free'. Employing the same technique use can be made of, for example, automatic writing. Artificial dream-induction and conflict-induction can also be practised under these conditions. The methods have been hailed by the indiscriminating as advances in analytic technique, whereas *the plain fact is that they constitute advances in hypnotic technique*. It is obvious that in the hands of an experienced analyst hypnosis can be more accurately exploited. But it must be equally obvious that the fundamental incompatibility between psycho-analytic and hypnotic methods cannot be overcome by setting hypnosis in a framework of analysis. The essence of transference-analysis is the analysis of *transferences* not the activation of an *immediately infantile object-relation* to the analyst. As far as is humanly possible the analyst is careful to avoid playing the role in which he is cast by the patient's unconscious displacement to him of infantile situations which in their time were either real or phantastic. In hypnosis the hypnotist deliberately activates parental transferences in order to induce a state of trance. The immediate effects of hypno-analysis are transference effects.

What has been said of hypno-analysis applies with even greater force to *narco-analysis*. The use of narcotic, hypnotic, or intoxicating substances to abolish the inhibiting effects of superficial preconscious function (usually but inaccurately described as conscious inhibition) has been practised ever since man discovered alcohol. The technique is as old as drug-addiction or as hypnosis. The only difference is that in narco-analysis drugs like sodium amytal or pentothal or nitrous oxide are applied by an analytically trained physician with the deliberate intention of reaching deeper layers of the pre-conscious system or possibly loosening the affects that keep the repression barrier in active

function. The fact that the analyst in intervals between inducing narcosis carries out a regular 'analysis', guided however by whatever material may have emerged during narcosis, does not entitle him to suggest that the situation is a true analytic situation. And the fact that he abolishes waking consciousness by means of drugs, i.e., not, as in the case of hypnosis, through exploitation of spontaneous rapport prejudices the analysis of transference still more hopelessly. It would be more appropriate therefore to speak of *controlled narco-therapy* than of narco-analysis. Incidentally both narco-therapy and hypno-therapy can be combined with 'analysis'. But this does not justify the suggestion that the 'analysis' is any more than an *exploration* such as is conducted with so-called 'short' analysis.

As in the case of other psycho-therapeutic methods quite striking results can be obtained by means of hypno-therapy and narco-therapy. As psychiatric war-experience demonstrated, the best results are obtained when recent traumatic events or emotional shocks have activated infantile traumata and so mobilised unconscious defences to a pathogenic degree. Like most short-cut therapies, narco-therapy and hypno-therapy are practised with the greatest gusto by non-analytical therapists. Incidentally it is of interest that experts in 'short' analysis claim to be able to produce just as much cathartic recovery as do the exponents of hypno-and narco-therapy.

Strictly speaking the use of psycho-analysis after *shock-treatment* – by insulin or electro-convulsive therapy – does not constitute a modification of psycho-analytic technique. It is sufficient to say that if a psycho-analyst has either recommended or given assent to preliminary convulsive therapy he should under no circumstances carry out the analysis himself but should delegate this task to someone who has not been in contact with the patient before. To say the least of it, it is unlikely that a patient analysed by anyone who has actually knocked him out or given him fits or who has condoned this pugilistic treatment will respond to his analyst with an uncomplicated transference reaction.

To conclude this review of resistance techniques, it is perhaps appropriate to point out that some years ago psycho-analysts themselves were much concerned with so-called *active techniques*. These were suggested by Ferenczi and consisted partly in inducing patients to undergo various abstinences of habit, both sexual and social, and partly in compelling them to abandon the neurotic precautions imposed on them by their hysterical phobias or obsessional rituals. Ferenczi justified these techniques on the ground that Freud had recommended analysis to be conducted in a state of 'abstinence', and

that by imposing abstinences and breaking down habits more repressed libido could be forced into the open and made available for analysis. Actually the interest in 'active therapy', as it was called, was partly a reaction to the extreme length of many analyses; consequently active technique was applied most frequently to cases of character disorder, which are notoriously more refractory to analysis than are cases of psycho-neurosis. For a time many analysts adopted these methods particularly during the terminal phases, but the procedure was looked on with misgiving by others, and after some years of experimentation it was allowed to lapse. There seems to be no doubt that the less frequently the analyst abandons his attitude of expectant neutrality the better for the analysis. Such interferences as are unavoidable in the interest either of the analysis or of the patient should be carefully timed and dosed. Nevertheless, increasing demand for analytic treatment renders it likely that active therapy will be revived in a modified form. This should be subject to the proviso that no course of action or inaction is suggested to the patient which would lead to the creation of a fixed and unanalysable transference situation. In many cases of psychosis, psychopathy and delinquent disorder an *elastic* technique cannot be avoided. Modifications of this sort are not however 'active' in aim: they are essential to the maintenance of an analytic situation.





## GLOSSARY

- Affects*: Emotional (as distinct from ideational) derivatives of instinct, feeling tones, associated respectively with instinctual tensions and discharges.
- Agoraphobia*: Morbid fear of open spaces.
- Aim-inhibition*: Unconscious exclusion of the erotic elements in early attachments to objects, leaving the tender aspects of the relationships undisturbed: the basis of much social feeling.
- Allo-erotism*: Psycho-sexual drives directed towards external objects.
- Alloplastic adaptation*: The discharge of instinctual stress through modification of external circumstances; as in normal and delinquent conduct. (compare autoplasic).
- Ambivalence*: A feeling-attitude towards objects during which opposing reactions are experienced simultaneously (e.g. love and hate) probably fused: can be consciously appreciated by the subject but is usually rationalised.
- Amnesia*: Defect of memory due to defensive withdrawal or exclusion of instinctual charges from ideas and associations provoking (or liable to provoke) psychic pain e.g., anxiety, guilt or emotional conflict: can be localised or massive, in which latter case a substantial area of the ego is usually dissociated.
- Anaesthesia*: Loss of feeling or sensation.
- Anal erotism*: Libidinal excitation of the anal and circum-anal area; either active or passive.
- Anamnesis*: Case-history.
- Anorexia*: In its hysterical form loss of appetite and aversion from food leading sometimes to complete refusal.
- Anti-cathexis*: An essential part of the unconscious processes of repression reaction-formation, character-formation etc., whereby the investment of ideas differing from or antithetical to ideas that cause or are likely to cause emotional conflict prevents the emergence of the latter in consciousness: the nearest conscious process comparable with anti-cathexis is trying to 'change the subject' (see cathexis).
- Anxiety-hysteria*: A neurosis in which anxiety is experienced in connection with a specific situation representing unconscious conflict: a compromise-formation having specific mental content and representing both repressed and repressing forces.
- Anxiety-neurosis*: Disturbances of the functions of psychic stimulation and discharge due to damming-up of libido giving rise to characteristic symptoms of anxiety and of somatic disorders which have however no psychic content.
- Aphonia*: Loss of voice.
- Aura*: Disordered sensations, e.g., of coolness or wind, preceding an epileptic seizure.
- Auto-erotism*: The experience of sexual excitation and/or gratification through physical stimulation by the subject of his own body or through phantasy of sexual activities.
- Autoplasic adaptation*: The discharge of instinctual stress through modification of the person's body or mind.
- Bisexuality*: Constitutionally, the inheritance of both masculine and feminine tendencies; unconscious or conscious feeling for persons of both sexes.
- Callus formation*: Circumscribed hardening and thickening of the skin.
- Castration complex*: Unconscious nexus of phantasies with associated anxiety affects concerning the (punitive) mutilation of male or female genitalia (usually the penis or clitoris) by parental objects.

*Catatonia*: A regressive form of insanity classified under schizophrenia or dementia praecox.

*Catharsis*: The discharge through consciousness of the affects associated with conflict or traumatic experience.

*Cathexis*: The investment of an idea with instinctual energy giving rise ordinarily to interest and to affect appropriate to the aim of the instinct: an unconscious process fully experienced in consciousness only when there is no unconscious obstacle to the emergence of the impulse (see anti-cathexis).

*Censorship*: Originally thought of as the (unconscious) function instigating repression: now regarded as a general scrutinising function of the super-ego.

*Claustrophobia*: A morbid fear of closed or contracted spaces or of emotional 'encirclement'.

*Coitus interruptus*: Interruption of coitus so that orgasm takes place outside the vagina.

*Coitus reservatus*: Prolonged coitus without orgasm or with delayed orgasm.

*Complex*: A nexus of repressed ideas with associated affects, as distinct from a conscious constellation of ideas.

*Component instincts*: A group of early infantile sexual instincts subsequently marshalled under the primacy of genital instincts; e.g., oral, anal, exhibitionistic instincts.

*Compromise formation*: The representation usually in disguised symptomatic form of both sides of an unconscious conflict, the repressed content and repressing tendencies being combined in one set of presentations or activities: observed also in illusion-formation and rationalisation, etc.

*Condensation*: An unconscious mechanism leading to superposition and subsequent fusion of elements of different ideational representations; observed in dream formation, wit, etc.

*Confusional states*: States of disorientation, either neurotic or psychotic.

*Constitutional factors*: Innate, inherited tendencies affecting physical and mental development: an important factor in symptom-formation.

*Contractures*: Shortening, distortion and shrinkage of muscles or their sheaths due to acute or chronic spasm.

*Conversion*: Symptomatic discharge of mental energies causing pathogenic conflict in the form of physical innervations and manifestations.

*Coprophagia*: Eating excreta.

*Coprophilia*: Libidinal interest in the excreta.

*Cover-memory*: A (usually early) memory which screens repressed memories of emotional significance.

*Cunnilingus*: Kissing, licking or sucking the vulva or anterior vagina.

*Cyclothymia*: A cyclical form of insanity with mild phases of elation and depression.

*Defaecation*: The act of emptying the bowel.

*Defusion*: The separating out of two components of instinct previously fused (q.v.): usually exemplified in the isolation of previously combined love and hate impulses.

*Delusion*: A false idea or belief devoid of rational judgement due to a regressive reactivation of unconscious phantasy.

*Dementia paranoides*: A form of schizophrenia exhibiting unorganised delusions of a paranoid type.

*Dementia praecox* (schizophrenia): A form of insanity characterised by deep and extensive regression.

*Depersonalisation*: The blocking (inhibition) of affective processes by means of strong anti-cathexes, leading to feelings of narcissistic estrangement.

*Dermographia*: Hysterical condition in which the action of writing on or marking the skin is followed by a persisting flush or weal.

- Diphasic formation*: Clinically a symptom formation occurring in two stages, one in which the repressed wish obtains disguised representation, and the other during which repressing forces are represented.
- Dipsomania*: A form of alcohol-addiction characterised by periods of powerful compulsion to drink and acute intoxication.
- Dispareunia*: Painful sexual intercourse.
- Dissociation*: Splitting off from consciousness of parts of the ego or of mental content (ideas and affects).
- Distortion*: The effects produced by dream mechanisms whereby the latent content of a dream is rendered unrecognisable.
- Dream states*: Neurotic states, mainly of a hysterical type, closely resembling the state of dreaming, due to withdrawal (introversion) of libido and overcharge of unconscious phantasy formations: similar to somnambulism.
- Echolalia*: Automatic repetition of words heard.
- Echopraxia*: Automatic repetition of observed actions.
- Ego-ideal*: Now regarded as (pre)conscious standards of individual attainment: incentives to 'ideal' behaviour.
- Ego-instincts*: A term originally applied to the non-sexual instincts operating directly in the interests of the ego, e.g., self-preservative instincts: later the self-preservative instincts were recognised as also libidinal in nature and all instincts were relegated to the Id system (q.v.)
- Ejaculatio praecox*: Orgasm before or immediately after penetration of the vagina.
- Empathy*: The affective tone of positive identification: appreciation of the affective state of another.
- End-product*: The final (ideational or affective) expression of an instinct.
- Enuresis*: Bed-wetting.
- Ereutophobia*: Morbid fear of blushing.
- Erogenic zones*: Areas of the body associated with erotic experience, e.g., mouth, anus, skin, genital.
- Erythematata*: Rose-coloured skin-rashes.
- Etiology*: Theory of causation of disease.
- Euphoria*: Pleasurable excitement; a mildly exaggerated and generalised feeling of well-being.
- Exhibitionism*: The attainment of erotic pleasure through display of any sexual body zone, or of the body as a whole.
- Fabrication*: A form of conscious phantasy activity similar to secondary elaboration: giving direct expression to unconscious as well as conscious elements.
- Fellatio*: Kissing, licking or sucking the penis.
- Fetishism*: The attainment of sexual gratification (usually) exclusively from non-genital parts of the body or from the clothing of the sexual object: may be displaced to clothing in general or non-personal fabrics and articles.
- Fixation*: The partial or total arrest of libidinal instinct or of parts of the ego at early stages of development; also refers to binding of instincts to early objects.
- Frigidity*: Lack of sexual gratification in coitus; may be partial or total.
- Fore pleasure*: Usually applied to sexual impulses: the gratification of component impulses as a preliminary to genital coitus.
- Fugue*: A hysterical form of flight usually associated with a state of dissociation.
- Fusion*: A usually permanent admixture of two instincts, e.g., aggressive and sexual instincts: seen in the earlier sadistic phases of libidinal development but involves genital libido also: can be applied to mixed affects.
- Globus hystericus*: Hysterical symptom experienced as a feeling of a lump in the throat preventing swallowing: due mainly to unconscious fellatio phantasies, particularly in women.
- Granulation tissue*: Fleishy tissue formed in open wounds.

*Guilt*: The affective function of conscious and unconscious conscience: an internalised form of anxiety, due primarily to frustration but canalised through conflict between the ego and super-ego, thereby giving rise to a feeling loss of love on the part of the ego: consciously guilt is experienced as a feeling of unworthiness, unconsciously it is better described as a 'need for punishment'.

*Hallucination*: Mental impressions having sensory vividness occurring in the absence of external stimuli and due to the regressive activation of unconscious phantasies in sensory form.

*Hebephrenia*: A form of schizophrenia characterised by intense excitement, depression and incoherence of thought.

*Heterosexuality*: The existence of sexual impulses towards persons of the opposite sex.

*Homosexuality*: The existence of sexual impulses towards persons of the same sex.

*Hyperacusis*: Morbid sensitiveness to sound.

*Hyperaesthesia*: Morbid acuity of sensation.

*Hypersecretion*: Increased secretion.

*Hypertension*: Increase pressure, e.g., in arterial system.

*Hypertonus*: Increased tonicity.

*Hypochondria*: Morbid anxiety regarding the condition of the body-organs or morbid sensations of disorder in those organs, the result of disturbance of body- or organ-libido.

*Hypomania*: Mild mania.

*Hypomotility*: Diminished motility.

*Hyposecretion*: Diminished secretion.

*Hypotonus*: Diminished tonicity.

*Id*: The unorganised and therefore non-personal part of a psyche: a reservoir of instinctual forces: unconscious in both dynamic and descriptive senses of that term.

*Identification*: The earliest type of positive relation to an instinctual object: a primitive unconscious tendency of the mind to equate different objects and to fuse different ideas.

*Illusions*: Misinterpretations of external stimuli or mistaken conceptions due to the interference of unconscious phantasies.

*Imago*: An organised unconscious image, e.g., of parental objects of instinct or their substitutes.

*Impotence*: Incapacity to achieve erection of the penis or penetration of the vagina.

*Incest*: Sexual gratification or the (usually unconscious) wish for sexual gratification with a member of the same family.

*Inhibition*: Usually applied to the unconscious impeding of instinctual gratification through restraint of function.

*Introjection*: A general unconscious tendency to psychic incorporation of environment: best illustrated by the adsorption of abandoned instinctual objects to the ego, leading to the formation of the super-ego.

*Introversion*: The withdrawal of libido from external objects leading to an investment of conscious and unconscious phantasy formation; often a preliminary to symptom-formation.

*Inversion (sexual)*: Homosexuality.

*Involuntional changes*: Regressional changes best illustrated in the 'change of life' (climacteric): observed in both sexes after middle life.

*Isolation*: An unconscious mechanism operative particularly in the obsessional neuroses, whereby traumatic experiences lose their ideational associations and emotional significance: a kind of circumscribed dissociation in which however memory of the event is undisturbed.

*Klang-association*: Association of ideas through superficial similarities of word-sound.

*Lalling*: Babbling of an infantile type.

*Latency period*: The period between the close of infantile sexual development and the onset of puberty (usually from 4-5 to 11-12).

*Libido*: The energy of sexual instinct in its broadest sense.

*Lysis*: Gradual abatement of a disorder.

*Manic-depressive insanity*: Characterised by alternating phases of psychotic depression and mania.

*Masochism*: The attainment of sexual gratification through mental or physical injury at the hands of the sexual object.

*Masturbation*: The induction, by the subject, of sexual excitation through manual (or other) forms of stimulation of erotogenic zones (or other parts) of the body, usually of the genital organs and areas.

*Megalomania*: An inflation of the ego leading to the delusional belief that the person has exceptional powers and is of exceptional importance: pathological grandiosity.

*Memory-trace*: A basic concept on which the idea of psychic structure is based: a permanent alteration in the unorganised *Id* caused by experience of psychic excitation or sensory stimulation, and reactivation of which lights up the memory of the original experience.

*Metapsychology*: Depth psychology: involving a threefold approach to mental activity viz. dynamic, structural and economic.

*Mutism*: Complete absence of utterance even in response to questions.

*Narcissism*: A preliminary stage in the organisation of the ego during which the individual's libidinal instincts are satisfied for the most part autoerotically and when their love aspects are concentrated mostly on the idea of the self: recognition of some important instinctual objects may exist but is not organised in such a way as to promote permanent differentiation of the ego from the world of objects. The ego is for the most part a body-'ego', developing from nuclear centres.

*Narcissistic libido*: May be primary or secondary: its *primary* sources are ultimately corporeal: *secondary* narcissism is derived from libido once attached to objects but for one reason or another permanently withdrawn and attached to the ego.

*Narcolepsy*: A condition characterised by recurrent attacks of falling, deeply asleep.

*Negativism*: The production of responses opposite to those normally elicited by a given stimulus; doing the exact opposite of whatever action is suggested.

*Neurasthenia*: Chronic fatigue accompanied by disordered sensations, irritability and inhibition of various ego-functions, following disturbance in the balance of excitation and discharge of instinct; has no specific mental content.

*Neuro-psychiatry*: A hybrid profession combining study of the (organic) nervous system with formal understanding of psychic (mental) activity.

*Nuclear complex*: The Oedipus or incest complex.

*Nucleus*: Term applied by the author to primitive elements of ego-structure developing before the stage of ego-synthesis: organised memory-traces (q.v.) laid down through experiences of instinctual excitations (appetitive and reactive) and sensory stimulations occurring during the various infantile primacies of instinct; can be sub-divided in accordance with the nature of the instinct mainly involved or in accordance with ego and super-ego aspects of its function.

*Object(s)*: That person or thing towards which instinctual urges are directed and on which they can be adequately gratified.

*Object-choice*: The selection of a particular object in preference to others.

*Object-libido*: Energy of the sexual impulses directed towards external objects.

*Obsessional neurosis*: A neurosis characterised by the dominance of compulsive feelings, thoughts, speech or actions (rituals): associated with exaggerated doubt and indecision.

*Oedipus complex*: The unconscious nexus of phantasies and associated affects concerned with impulses to have sexual intercourse with the parent of the opposite sex: this is the *positive* Oedipus complex: desire for sexual relations with the parent of the same sex is now described as the *negative* Oedipus complex: in both cases the complex includes phantasies associated with the desire to destroy the rival parent.

*Ontogenetic*: Pertaining to the development of the individual.

*Oral erotism*: Libidinal excitations arising from stimulation of the mouth or circum-oral area: either active or passive.

*Organ-neuroses*: Functional disorders of organs caused by psychogenic factors but having no specific mental content, e.g., peptic ulcer.

*Oro-phallic complex*: A complex in which the main elements are contributed from oral and genital sources, sometimes in a state of fusion.

*Paraesthesia*: Perverted sensation.

*Paranoia*: A form of insanity characterised by more or less organised delusions, commonly of a persecutory nature.

*Paraphrenia*: Sometimes used to cover both schizophrenia and paranoia; usually refers to a variety of paranoid dementia.

*Paresis*: Partial paralysis.

*Pathognomonic*: Characteristic of a diseased process.

*Patho-neuroses*: The development of neurotic symptoms localised at an area previously affected by organic disease.

*Peptic ulcer*: Ulceration of the mucous membrane of the stomach or duodenum.

*Perceptual consciousness* (pcpt-cs.): A psychic sense organ promoting the perception and differentiation of psychic qualities and quantities of excitation.

*Perversion*: Deviation from the normal: applied usually to sexual deviations: these are sub-divided in accordance with the aim or object of the perverted instinct or instinct-component: is used also to designate character changes of a disordered type.

*Phallic phase*: The phase of infantile sexual development during which interest in the penis predominates: applies to both sexes.

*Pharmacotoxic state*: Toxaemia (poisoning) due to administration of drugs.

*Phobia*: A fixed morbid fear of an object, idea or situation that does not ordinarily justify fear.

*Phylogenetic*: Pertaining to the development of the race.

*Pleasure-pain principle*: The tendency of the primitive psychic apparatus to avoid 'pain' at all cost: leads to persistent attempts to gratify primitive impulse without reference to reality conditions.

*Preconscious* (pcs.): A psychic system the content of which is not immediately conscious but is capable of recall: governed by secondary mental processes.

*Pregenital impulses*: Infantile sexual impulses existing prior to the development of infantile genital primacy of impulse; e.g. oral, anal.

*Primary gain*: The unconscious advantages or gratification secured by the ego through illness.

*Primary processes*: Originally the regressive tendency of the mental apparatus to secure gratification through activation of internal perceptions (hallucinations): includes all processes by which the unconscious or *Id* seeks to increase possibilities of gratifying unmodified instinct, e.g., as in the dream mechanisms of *condensation* and *displacement*: primary processes ignore time, reality or logical considerations.

*Prodromal*: Indicating the onset of disease.

*Projection*: An unconscious process supporting the primary pleasure principle whereby emotions and excitations giving rise to psychic pain are felt as being outside the ego and attributed to some other person: the basis of animistic systems.

- Pseudo-cystitis*: Hysterical disturbances resembling the symptoms of inflammation of the bladder.
- Psychopathic*: Reserved for the description of psychopathological states which are neither psychotic nor neurotic in nature but which exhibit instability in emotion, thought and behaviour: psychopaths are frequently both antisocial and sexually perverted and were once described as 'moral imbeciles'.
- Psycho-somatic reactions*: Comprise the organic changes consequent on affective charges, the organic manifestations of dammed up instinct and the physical consequences of unconscious attitudes or unconsciously determined behaviour patterns.
- Rationalisation*: An unconsciously determined falsification of motives for affective expression and behaviour, the object of which is to justify irrational behaviour by manufacturing rational causes for it. Within certain limits the rationalisation may be sound enough.
- Reaction-formation*: An unconscious mechanism of the anti-cathexis group whereby an unconscious or repressed impulse is held in check or completely concealed by the activation of impulses and ideas having an opposite tendency. When sufficiently organised reaction-formations give rise to distinct character traits.
- Reality principle*: The tendency of the mental apparatus to control the immediate gratification of primitive instincts in order that the ultimate gratification may be more or less in accordance with the conditions imposed by reality, including social and ethical codes.
- Regression*: An unconscious mechanism, involving the withdrawal of psychic energy from a more advanced psychic level of function to a more primitive one, e.g., from genital to pre-genital interests; from reaction-formations to ideas of persecution; from object relations to narcissism. Regression can also affect the immediate derivatives of instinct, i.e., ideas and effects. Ideas can regress from a conceptional form to their original sensory (auditory or visual) constituents: compound affects can regress to their primary (primitive) forms. Observed normally in sleep, day dreaming and most situations of relaxation and recuperation.
- Repression*: An unconscious mechanism capable of producing oblivescence of instinctual derivatives both affective and ideational: in its primary form prevents the emergence of unconscious ideas by the mobilisation of counter-charges (anticathexes): in actual repression however cathexis is also withdrawn from pre-conscious derivatives of unconscious function.
- Resistance*: The head of opposition developed by unconscious defence-mechanisms in the face of any effort to render unconscious content conscious: applies mostly to the defences aroused by the use of psycho-analytic technique.
- Sadism*: Experience of sexual excitation and/or gratification during the infliction of bodily or mental pain on another person.
- Scopophilia*: Experience of sexual excitation and/or gratification from visual activity: the main element in sexual 'viewing': hence the counterpart of exhibitionism.
- Secondary elaboration*: A defensive elaboration of dream processes whereby some apparently logical order is introduced into the formations: a (pre)conscious mechanism.
- Secondary gain*: The usually pre-conscious exploitation of a neurosis or other morbid state to acquire personal advantages or compensation, e.g., additional security, financial compensation, preferential treatment especially in the family circle.
- Secondary processes*: Mental processes by which the ego in the interests of reality seeks to inhibit or modified primary instinctual drives: largely associated therefore with preconscious systems; culminate in the exploitation of intelligent (logical) judgement.
- Somatic*: Pertaining to organic function.



**Somatic compliance:** A complex of factors influencing the choice of a particular area or body zone as a locus of symptom-formation: primarily induced by physico-chemical factors of a hormonal type, it is decisively influenced by the distribution of body and organ-libido, in particular the erogenicity of various sexual zones: can be complicated by the effect of previous organic disease on the libidinal investment of any given organ.

**Somnambulism:** Sleep-walking.

**Sphincter:** Muscle ring controlling, e.g., oral and anal apertures.

**Sublimation:** An unconscious process whereby infantile libidinal energies are desexualized and transferred to augment non-sexual drives.

**Super-ego:** An early form of ego-differentiation brought about by introjection (q.v.) of abandoned instinctual objects: exercises a scrutinizing and censoring function towards Id (instinctual) excitations and ego activities: commonly called 'unconscious conscience'.

**Symbolism:** An archaic prelogical form of thinking which follows the primary process and can be used as a form of defence, e.g., a conscious idea can cover an unconscious or repressed presentation: symbols are typically sensorial and concrete, have constant meaning and are independent of individual factors.

**Symptomatic act:** Independent, unintended actions giving usually symbolic expression to unconscious wishes.

**Syndrome:** A group of clinical signs or symptoms characteristic of any given disorder.

**Tachycardia:** Rapid action of the heart.

**Talion law:** A primitive and retributive principle of animistic origin, whereby the culprit suffers the same kind of injury as he inflicts: 'an eye for an eye'.

**Torticollis:** Wry-neck.

**Toxaemia:** The effect of absorption of poisons either ingested or formed in the tissues or derived from bacterial infections.

**Transference:** In principle a displacement of excitation-affect from one psychic situation or presentation to another: generally applied to the displacement, during analysis, of the patient's infantile reactions, either friendly or hostile, to the personality of the analyst.

**Transitional states:** A clinical designation based on developmental classification of mental disorders and implying a 'series in depth': can be applied to any form of disorder lying between the main points in a developmental series, e.g., between obsessional neurosis and hysteria: specially applied by the author to designate drug-addictions which lie between the psychoses and the neuroses.

**Transvestitism:** The experience of sexual excitation and/or gratification through wearing clothes of the opposite sex.

**Traumatic neurosis:** A massive functional disturbance affecting both mind and body precipitated by excessive bodily or mental injury or excitation: usually affects persons constitutionally predisposed to disorder of the psychic functions of excitation and discharge.

**Unconscious (ucs.):** In its original sense a psychic system the content of which, unlike that of the pre-conscious (pcs.), is incapable of being rendered conscious by any ordinary effort: subsequently differentiated into the Id, the specifically 'repressed' and unconscious parts of the Ego (including super-ego): to be clearly differentiated from the 'sub-conscious', a term rejected by psycho-analysis as having no specific structural or dynamic connotation.

**Urethral erotism:** Experience of sexual excitation and/or gratification in the act of urination.

**Vegetative irritability:** Over-excitability of the autonomic or sympathetic nervous system.

**Word-salad:** A flow of apparently unconnected substantives, capable, however, of consistent interpretation in terms of unconscious content.

## LIST OF BOOKS RECOMMENDED

The task of producing text books that might at the same time serve to introduce students to psycho-analytical theory and give an adequate outline of its clinical applications has been seriously neglected by psycho-analysts. For the matter of that there are few text books that give a comprehensive presentation suitable for the needs of psycho-analytical practitioners. Freud occasionally toyed with the idea and got so far as to write two sets of correlated papers, one on theory and the other on technique. But he ultimately abandoned the project of a systematic text book. A number of his early followers produced volumes of collected papers in which 'introductory' articles were interspersed with clinical contributions. Some of these are still worth perusal by students who are ready to work their way through bulky publications. But no attempt has been made to meet the requirements of those whose profession calls merely for understanding of psycho-analytical diagnosis. Under these circumstances the reader must be content to pick his way through standard analytical literature. The following suggestions are made in the hope that they may spare him superfluous effort.

**SIGMUND FREUD.** Although many of Freud's books and papers are so highly technical as to be beyond the scope of the unoriented reader, his expository writing remains unsurpassed for simplicity, clarity and style. The reader cannot do better than begin by studying his *Introductory Lectures on Psycho-Analysis* (London, Allen and Unwin). Originally delivered at the University of Vienna, this collection of lectures is the best possible introduction to the subject and covers Freud's theoretical views down to the period when he launched his theory of super-ego development. Modifications in his theory of anxiety and of the ego-instincts were described in later volumes. These modifications however do not disturb the clinical outlines given in the *Introductory Lectures*.

Freud's later metapsychological formulations may be said to date from the publication of his *Beyond the Pleasure Principle* (London, Hogarth Press). This however is an extremely difficult book and is mentioned here only because it prepared the way for his most important presentations of ego-psychology, viz., *Group Psychology and the Analysis of the Ego* (London, Hogarth Press) and *The Ego and the Id* (London, Hogarth Press). Neither of these monographs is particularly easy but the second at least cannot very well be omitted from any systematic reading. A more general survey of his later views on instinct, anxiety, guilt and ego-formation is to be found in *Civilisation and Its Discontents* (London, Hogarth Press), a book which is in any case worth reading for its scope, breadth of thought and clarity of presentation. Another useful summary of his theoretical position is given in the *New Introductory Lectures on Psycho-analysis* (London, Hogarth Press). Unlike the original *Introductory Lectures*, this is not a systematic presentation.

On the clinical side the student is recommended to begin with the *Introductory Lectures* and to continue with *Three Contributions to the Theory of Sex* (New York, Nervous and Mental Disease Monographs). This is an extremely condensed monograph but is essential to an understanding of psycho-sexual difficulties. As a useful preamble to the study of symptom-formation, his *Psycho-pathology of Everyday Life* (London, Benn) should then be read. Freud's analysis of slips and systematic acts gives a clear insight into the dynamics of symptom-formation and of the relations between the various psychic systems. The same can be said of his *Wit and Its Relation to the Unconscious* (Fisher Unwin) which however may be omitted by the more general reader. Some of the most illuminating of Freud's clinical contributions are to be found in vols. ii and iii of his *Collected Papers* (London, Hogarth Press.)

Vol. ii covers a wide range of disorders and almost every paper includes fresh observations of a theoretical nature. Vol. iii is of considerable historical value including as it does a number of extended case-histories.

Many students begin their reading with Freud's *Interpretation of Dreams* (London: Allen & Unwin). This is not generally advisable: for although it is the standard text book on the subject it can be appreciated best by students who are already familiar with the outline of psycho-analytical theory. As an introduction to the subject of dreams other and simpler papers and books should be consulted (see below). The *Interpretation of Dreams* is however of considerable historical interest to the student of theory, for in its theoretical chapters Freud first outlined his views on the structure and function of the mental apparatus.

Finally a useful general selection from the works of Freud is to be found in the *Psycho-analytical Epitomes* (London, Hogarth Press).

Needless to say it is neither necessary nor indeed desirable to work through the above list consecutively. Once the outlines of Freud's theory have been grasped and its main clinical applications understood, the student will find that the task of revision and recapitulation can best be carried out by more discursive reading. The following list is arranged in a rough order of priority, corresponding to the outline given in this book.

ERNEST JONES. *Papers on Psycho-analysis* (London, Bailliere, Tindall and Cox, 4th Edition).

This is one of the most systematic 'collections' of psycho-analytical papers. It includes some extremely lucid presentations of psycho-analytical theory, e.g., the dynamic relations of the various psychic systems, the processes of dream-formation and of symbolism, the nature of suggestion; also some intensive clinical studies of the neuroses. The Third Edition is perhaps more suitable for the beginner, since in the latest edition a number of clinical papers have been omitted to give place to an *ex-parte* presentation of controversial views on early development, in particular the sexual development of women.

KARL ABRAHAM. *Selected Papers on Psycho-analysis* (London, Hogarth Press). After Freud, Abraham was one of the most brilliant clinical investigators. His papers range over a diversity of clinical conditions, are written with simplicity and clarity and at the same time give the reader an intimate understanding of the mechanisms of symptom-formation. Abraham also devoted special attention to stages in the development of the libido and their influence on character formation. His clinical perspective was excellent and his psychiatric experience enriched rather than retarded his understanding of mental disorder.

SANDOR FERENCZI. *Contributions to Psycho-analysis* (Boston, Badger), *Further Contributions to the Theory and Technique of Psycho-analysis* (London, Hogarth Press). Ferenczi combined in a remarkable degree a faculty for clinical insight and an imaginative psychic approach to the more difficult problems of mental disorder. From both historical and clinical points of view his earlier volume is well worth reading. *Further Contributions* has a wider range and is excellently suited to the student who likes not only to browse amongst clinical papers but to be compelled to think out clinical problems for himself. His later technical contributions were not widely accepted but are refreshingly free from formalism, a common failing of psycho-analysts.

OTTO FENICHEL. *The Psychoanalytical Theory of Neurosis* (London, Kegan Paul). This is a real compendium of psycho-analytical information, both clinical and theoretical. It is essentially a work of reference and errs a little on the side of indiscriminate quotation. But no serious student of psycho-analysis can afford to be without it. Some of the introductory chapters on various aspects of psychic activity and in particular of symptom-formation are extremely serviceable. The title is somewhat misleading, as the book deals also with many forms of psychosis, with character disorders, and with psycho-sexual inhibitions and perversions.

ELLA SHARPE. *Dream Analysis* (Hogarth Press).

Having studied some general outlines of the theory of dreams (see among others, JONES) the reader can acquire a more intimate understanding of the method of dream interpretation by reading Ella Sharpe's book. The elaborate interplay of mechanisms and content (dream-work) is well described by the writer who held that dream interpretation is as much an art as a science. For more advanced students the next step is to read Freud's standard work on the subject.

D. K. HENDERSON. *Psychopathic States* (Chapman and Hall).

Though not himself a psycho-analyst and critical of many aspects of psycho-analytical theory Henderson's psychiatric work has included many valuable studies of delinquent conduct and of the psychopathic states. The latter he describes with both clinical skill and breadth of vision. This book provides a useful addition to the, so far incomplete, psycho-analytical account of character disorders.

K. FRIEDLANDER. *The Psycho-analytical Approach to Juvenile Delinquency* (Kegan Paul, French, Trubner and Co.).

This is a reliable account of standard psycho-analytical views on juvenile delinquency and contains a useful general summary of the psycho-analytic theory of mental development with special reference to social adaptation.

ANNA FREUD. *Introduction to the Technique of Child Analysis* (Nervous and Mental Disease Monograph No. 48, New York). *The Ego and the Mechanisms of Defence* (Hogarth Press, 1937).

In view of the fact that markedly divergent tendencies have developed in psycho-analytical circles in Britain on the theory and practice of child-analysis, it is desirable for the reader to concentrate in the first instance on presentations of the subject based on generally accepted Freudian principles. Anna Freud's work conforms with this standard. Her book on *Defence Mechanisms* is not only written with characteristic clarity but gives an excellent account of those defensive functions of the ego which contribute to the form of what Freud once called the Defence-neuroses.

LAWRENCE S. KUBIE. *Practical Aspects of Psycho-analysis* (W. W. Norton, New York)

A practical handbook of service both to prospective patients and to their medical advisers. It is intended to promote a sound understanding between the psycho-analyst, the patient, the patient's family and the physician recommending analysis, to help the latter choose a suitable analyst and to answer the various questions raised by the patient.

EDWARD GLOVER. *The Technique of Psycho-Analysis* (Bailliere Tindall and Cox). *An Investigation of the Technique of Psycho-Analysis* (Ibid).

The first of these books consists of a series of lectures intended to outline the various phases and movements of the 'analytical situation' that develops during psycho-analysis; also to describe the various modifications in technique involved in the

gation of psycho-analytical technique by the questionnaire method. It is written for the use of more advanced students.

### OTHER BOOK RECOMMENDATIONS

A. AICHORN, *Wayward Youth* (Putnam, New York), on the treatment of psychopathic delinquents; R. BRUN, *General Theory of the Neuroses* (Allen and Unwin), containing a readable discussion of the role of somatic and psychogenic factors in the psycho-neuroses and psychosomatic disorders; J. C. FLUGEL, *Psychoanalytic Study of the Family* (Hogarth Press), a simple and persuasive if rather conservative account of general infantile development, specially suitable for timid or sceptical beginners; H. W. FRINK, *Morbid Fears and Compulsions* (Moffat, Yard, New York) an early presentation of psycho-analytical theories of the psycho-neuroses, still of considerable clinical value; M. LEVINE, *Psycho-Therapy in General Practice* (Macmillan, New York); M. SCHMIDBERG, *Children in Need* (Allen and Unwin).

### ARTICLES AND MONOGRAPHS

Students who have worked their way through the above reading list and wish to acquire a more detailed knowledge of psycho-analysis are recommended to concentrate at this point on a *systematic study* of the writings of FREUD. It is no exaggeration to say that although psycho-analytic literature has expanded rapidly in recent years very few important advances on Freud's own contributions have been made. Most of Freud's works have been published by the Hogarth Press, Allen and Unwin and the Imago Publishing Co. Having completed this by no means inconsiderable task the student is in a position to deal with special aspects of psycho-analysis. A useful summary of psycho-analytical literature is given in FENICHEL's *Theory of the Neuroses*. Many of the individual papers referred to are to be found in back numbers of the *International Journal of Psycho-analysis*, an Index to which was published in 1932 by Douglas Bryan (Bailliere, Tindall and Cox).

Amongst more specialised contributions papers by the following are recommended: On conceptual processes, I. HERMANN; on ego feeling and ego boundaries, P. FEDERN; on super-ego function, E. WEISS; on sublimation, S. BERNFELD; on feminine development, M. BRIERLEY, J. LAMPL-DE GROOT; on the general theory of neuroses, H. NUNBERG; on psycho-somatic disorders, F. ALEXANDER, S. E. JELLIFFE; on epilepsy, P. CLARK, I. HENDRICK; on stammering, I. CORIAT; on psycho-analytical psychiatry, P. SCHILDER, A. STAERCKE; on schizophrenia, M. KATAN; on depersonalisation, C. P. OBERNDORF; on suicide, K. MENNINGER, G. ZILBOORG; on alcoholism, R. KNIGHT; on drug addiction, S. RADO; on frigidity, E. HITSCHMANN; on female homosexuality, H. DEUTSCH; on male homosexuality, F. BOEHM; on the 'menstruation complex', C. D. DALY; on neurotic character, F. ALEXANDER; on child analysis and delinquency, M. SCHMIDBERG; on psycho-analysis in institutions, E. SIMMEL; on psycho-analysis and hypnosis, M. H. ERICKSON; on psycho-analytical sociology, J. C. FLUGEL, E. GLOVER, E. KRIS, H. LASSWELL.

# INDEX

- ABRAHAM, 213  
 Abreaction, 87, 218  
 Accessibility, of psychic products, 52, 137, of patient's mind, 199  
 Action, 57, 143-4, compromise -, 144  
 Activity, hyper -, 204, - passivity, 79, 81, 104, 254-5, 258  
 Adaptation, 43, 64, 68, 86, 92, 108, 120, 140, 150, 171, 186, 277, 320, effective -, 74, 82, 89, 157, 265, 299, fluctuation in -, 292, motive for -, 49, problem of -, 67, - to reality, 52, 287  
 Addiction, Alcohol -, 244, Cocaine -, 244, clinical types of -, 247, development of -, 246, fixation and -, 246, inhibited forms of -, 244, malignant -, 248, morphine -, 244, - and obsession, 245, prognosis of -, 247, 310  
 ADLER, 13, 333  
 Affect, 49, 55, 64, 68, 71, 74-5, 77, 91, 102, 123, 133, 140, 149, 150, 159, 171, 173, 204, clinical aspects of -, 49, compound -, 45-47, 173, 204, 212, discharge -, 43, 46, division of -, 45-7, disruptive -, 50, ideation and -, 54, painful -, 50, pleasure -, 50, - equivalents, 181, 195, 229, - in psychosis, 203, 221, primary -, 45-6-7, 204, rage -, 195, secondary -, 45-6-7, 204, - stereotypies, 229, - tension, 43, 45-6  
 Affective state(s), 43, 49  
 Afferent path, 15  
 Aggression, 30, 40-1, 56, 60, 65, 67, 83-4, 92-3, 98, 125, 128, 132, 153, 156, 162-4, 173, 175-6, 180, 183, 188, 191, 193, 204, 210, 213-4, 237, 252, 263, 276, 282-5, 288, - against self, 245, aims of -, 21, frustrated -, 40, phases of -, 41, sadistic forms of -, 42, 206, 255  
 Aggressive, - energies, 56, 285, - guilt, 218, - instincts (*see instincts*), - impulse (*see impulse*), - sexuality, 194, - tensions, 97, 210  
 Agoraphobia, 154  
 Aim(s), - of aggression, 41, conflicting -, 58, erotic -, 77, - of instinct, 33, 68, 73-4, 76, 84, incestuous -, 62, - inhibition, 76, 77, 166, modified -, 78, 80, - of object relationship, 227, perverted -, 254, sexual -, 108  
 Alcoholism, 81, 96, 101, 103, 105, 117, 244-6, 248, 258, 265, characteristics of -, 197, jealousy and -, 49, subgroups of -, 278  
 Allo-erotism, 38  
 Ambivalence, 48, 86, 106, 119, 163, 165, 212, 213, 237, 257, 285-6, 306, 330, anal -, 43, depression and -, 205, development of -, 213, 302, - and drug addiction, 246, 249, - to father, 262, genital -, 43, - to objects, 46, 234, 285, oral -, 43, primary -, 213, traumatic -, 285, - in sexual relations, 302, - in social relations, 302  
 Ambivalent, 154, 219, pre -, 213  
 Amnesia, 72, 92, 117, 119  
 Anaesthesia, 141, 147, 252  
 Anal, - character formation, 271, - ego-nucleus, 65, 239, - interest, 73, 60, 86, 97, - loss, 103, - masturbation, 293, - phantasies, 91, - primacy, 66, 211, - sadism, 41, 65, 101-2, 104-5, 129, 155, 164-5, 167, 183, 193, 306, - sexuality, 44, 174, - super-ego, 60, - zone, 35, 42, 255  
 Anamnesis, 50  
 Anger, 45, 49, 81, - and fear, 46  
 Animism, 28, 104, 226, 247, 291  
 Anorexia, 142  
 Anti-cathexis, 71, 73, 74, 81, 89, 90, 92, 226, 242, pre-conscious -, 79, 238, primary -, 80, projection and - 81  
 Anxiety, 23, 47, 48-9, 50, 55, 71, 76, 84, 94, 98, 104, 106, 116, 125, 129, 140, 143, 150, 152-3, 155, 157, 160, 162, 173-6, 178, 180-1, 184, 187-8, 191, 193, 195, 223, 225, 234, 237, 246, 248-9, 253, 262, 266, 282-3, 288-9, 290-1, 301, 307, 320, 326, archaic -, 197, castration -, 147, 211, 237, 246, 258, - depression, 183, 248, - dream, 112, fixed -, 150-1, floating -, 150-1, 181, 283, 290, frustration and -, 65, 70, 83, 181, 291, 293, genital -, 253, 306, guilt and -, 31, 49, 60, 71-2, 94, 106, 175, 190, 246, 252-3, 285, 294, - and hate, 25, - hysteria, 149 (*see Hysteria*), incestuous -, 259, - in infancy, 15, 259, 283, - manifestations, 48-9, 139, 150, 168, 181-2, 187, 232, 234, 248, 291, masturbation -, 155, morbid -, 47-8, 76, 154, mutilation -, 260, - neurosis, 170-2, 180-3, 187, 194-5, 198-9, 222, origin of - 47, projection -, 253, - in psychotics, 281, 242, pubertal -, 294, - readiness, 49, 101, 169, 176, 180, 182, 294, separation -, 187, 247, sexual -, 77, social -, 103,

105, 163, 193, 285, - thinking, 47,  
unconscious -, 37, 49, 75, 124, 154,  
215, 248, 253, 256, 266  
Apathy, 160  
Aphonia, 141  
Apprehensiveness, 47  
Archaic, - reaction, 52, - super-ego, 62  
Association, free -, 111, 120, 166, 280,  
315, 319, technique of -, 112, 113, 120  
Associative, - thinking, 112, 114, 118  
Asthma, 37, 141, 173, 175-6  
Aura, 196  
Auto-erotism, 88, 40, 78, 80, 98, 102,  
196  
Awareness, 52

#### BED WETTING (see *Enuresis*)

Behaviour, 14, 16, 43, 48, 61, 68, 73, 81,  
132-3, 144, 159, 163, 168, 171, 191,  
216, 239, 263, 299, adapted -, 69,  
268, codes of -, 44, 68, cyclothymic -,  
292, compulsive -, 291, delinquent -,  
274, 275, - disorders, 277-8, 282, 295,  
infantile -, 22, 70, 95, 179, obsessional  
-, 104, 158, paranoid -, 235, per-  
verted -, 132, psychotic -, 221, 280,  
regressive -, 292, super-ego and -, 58,  
63  
Behaviouristic, - evidence, 97, - stig-  
mata, 148  
Bestiality, 255  
Birth, - experiences, 47-8, 98, 114,  
153  
Blindness, 142  
Blushing, 142, 146  
Body, - libido (see *libido*)  
danger to -, 44, - objects, 86  
Breakdown, 101, 123, 129, 145, 148,  
174, 295-6, mental -, 41, 83, 242,  
247, narcissistic -, 242, neurotic -,  
56, 124, precipitating factors in -, 56,  
67, psychotic -, 39, 56, 116, 169, 242,  
schizophrenic -, 222-3, 227, sexual -,  
244, social -, 244, - of sublimations, 78

#### CANNIBALISTIC PHANTASIES, 24, 25, 36, 193, 210

Cardio-vascular, - disturbances, 47,  
176, - system, 48  
Castration, 60-1, 146-7, 152-6, 165,  
174, 179, 188, - fear, 106, 155, 185,  
211, 237, 253, 257-9, 272, 291, par-  
tial -, 194, - phantasies, 156, self -,  
217  
Catatonia, 56, 148, 190, 193, 195, 220,  
226, 229, excitement in -, 224, de-  
pression and -, 224, stupor in -, 224  
Catharsis, 143, 199, 200, wit -, 89  
Cathexis, 54, 68, 70, 74, 76-7, 80, 91-3,  
98, 100, 114, 130, 144, 164, 184, 213,

218, 236, hyper -, 90, 143, 188, 211,  
226, narcissistic -, 185, 211, 225,  
object -, 218, 226, 227, pre-conscious  
-, 76, 79, 89, withdrawal of -, 56,  
71-3, 78, 80, 82, 205, 207, uncon-  
scious -, 75, 79, 81, 89, 126-7,  
184-5, 188

Censorship, 57, 89, 105, dream -, 113

Central Nervous System, 33

Character, 33, 62, 73, 104-5, 132-3, 138,  
148, 168, 261, 266, 270-1, 272, 277,  
299, 303, anal -, 271-2, anti-social  
-, 265, depressive -, 132, 265, 269,  
311, - disorders, 44, 45, 51, 265-6,  
268, 270, 272, 275, 277, 308-9  
- formation, 27, 89, 96, 105, 202, 227,  
231, 234, 271, 294, 308, genital -,  
271-2, hysterical -, 74, 132, 268, infan-  
tile - reaction, 14, - instability, 244,  
narcissistic -, 270, neurotic -, 202,  
obsessional -, 132, 265, 269, 277,  
oral -, 271-2, paranoid -, 132, 202,  
269, - peculiarities, 13, 73, 125, 234,  
250, 268, 270, 274, 308, psychotic -,  
202, - reactions in mania, 207, schizo-  
phrenic -, 202, schizoid -, 269

Child Guidance Clinics, 329

Child(hood), 14, 52, 60, 77, 203, 219,  
229, 234, 242, 250, 275, 278, 281-2,  
286, 288, 295, 302, anxiety in -, 15,  
232, 313, - development, 28, 216,  
274, 288, diagnosis in -, 313, -  
disorders, 14, 31, 284-5, 287, 293, 294,  
dreams in -, 98, mental disorders  
in -, 14, 280, 285, 287, 313, neurotic -,  
292, phobias in -, 233, - play, 27,  
287, psychoanalysis of, 14, 280,  
295, 296, 335, - psychology, 209,  
292, psychotic -, 292, sexual theory  
in -, 267, trauma in -, 52, 304

Choreiform movements, 190

Classification, 69, 132, 151, 163, 175,  
264, - of affects, 45, - of aggressive  
impulses, 41, - of character disorders,  
270, 307, 308, - of childhood dis-  
orders, 289, - of delinquencies, 272,  
273-4, 276, clinical -, 41, 51, 220,  
243, confusion in -, 265, 278, - of  
conversion states, 140, 142, - of dis-  
orders, 288, - of dreams, 111, - of  
instincts, 33, - of intellectual activity,  
92, - of marital disorders, 261, - of  
mental disorders, 15, 17, 66, 72, -  
of mental mechanisms, 69, - of per-  
versions, 254, - problems, 97, psy-  
chiatric -, 96, 170, 189, 264, - of  
psychoses, 203, 220, 224-5, 227, 234,  
243, 276, serial -, 195, standards of -,  
264, - of sexual disorders, 252, 254

Claustrophobia, 152, 154

- Climacteric, 176, 270, post - psychoses, 96, 123
- Cocaine, addiction, 244, 247, 310
- Coitus, - interruptus, 181, 253, parental -, 188, - reservatus, 253
- Complex, homosexual -, 175, nuclear -, 37, 147, 233
- Components, - of instinct, 45-6, infantile sexual -, 193, 210
- Compulsion(s), 61, 160-3, 245, 263, 291, sexual -, 50, - Neuroses (*see Obsessional*)
- Compulsive, - aversions, 244, - delinquency, 275, - masturbation, 183, 285, - thoughts, 127
- Concept(s), basic -, 54, 67, 84, 95, 100
- Condensation, 53, 69, 89, 112-13, 126, 228
- Confession, 161
- Conflict, 14, 16, 18, 38, 41, 62-3, 65, 68, 73, 77, 88, 91, 94, 106, 110-11, 116-17, 119, 120, 122-23, 125-27, 131, 136, 140, 148, 156, 163, 171, 177-8, 182-3, 187, 189, 193, 195, 208-9, 215, 224, 227, 250, 255-6, 267, 285, 326
- ego and super-ego -, 210, 215, 218, - between parents, 81, 215, - defences, 181, 184, 200, homosexual -, 248, incestuous -, 105, 293, infantile -, 35, 73, 83, - level, 217, 240, 270, 307, 308, 312, menopausal -, 219, mental -, 43, 48, 87, 174, 299, moral -, 251, neurotic -, 191, oral-sadistic -, 101, - in psychoses, 240, - resolution, 18, 314, unconscious -, 38, 50, 63, 74, 76, 88, 140, 143, 182-3, 192, 244, 250, 266, 300, 306, 312, 314-15, 320
- Conscience, 58, 61, 62, 207, 285
- Conscious, 38, 44, 51-3, 55, 57-8, 64, 68, 70, 73, 75, 87, 90, 102, 118, 120, 123, 164, 237, 242
- Consciousness, 15, 22, 44, 45, 51-6, 64, 69, 71, 73, 81, 87, 110-12, 122, 126, 141, 143, 149, 153, 188, 239
- Constipation, 142
- Constitutional, - factors, 178, 222, - variations, 100-1, 128, 172
- Conversion, - hysteria (*see Hysteria*)
- Convulsions, 148, 170, 218, affective -, 195, epileptic -, 218, regression and - 196, traumatic -, 195
- Convulsive states, 194, 195, 196
- Cramps, 141, Pianist's -, 143, Writer's -, 143
- Crime, 219
- Curiosity, 78
- Cultural development, 49
- Cyclothymia, 205, 245, - ic addiction, 247, - ic reaction, 291, 292
- DANGER, 23, 44, 47-9, 69, 73, 81, 103, 152-3, 190, 222-3, 229, 233, 268, - signal, 56, 79, 153, 215
- Day-remainders, 111
- Deafness, 142
- Death wishes, 61
- Defense, 104, 107, 114-15, 125, 149, 150, 153, 155-6, 164, 169, 175, 179, 185, 190, 226, 241, - affect, 177, anxiety -, 195, conflict -, 181, 184, 186, 200, depressive -, 212, ego -, 217, functional -, 186, 191, 200, introjective -, 103, - mechanism, 69, 77, 92-3, 98, 123, 181, narcissistic -, 234, projective -, 88, psychotic -, 253, - reactions, 69, 93, 96, 191
- Delinquency, 61, 105, 132, 137, 163-4, 266, 272-3, 275-6, 278, 293, 307, compulsive -, 275-6, juvenile -, 208, 294, paranoid -, 276, psychopathic -, 216, prognosis of -, 311, sexual -, 265, social -, 274, treatment of -, 317-18
- Delusion, 53, 61, 89, 92, 156, 183, 204, 206-8, 210, 216, 224, 226, 228, 234, 237-8, 242, erotomaniac -, 235, diffuse -, 239, - formation, 94, grandiose -, 235, homosexual -, 236, - of jealousy, 231, 245, 262, paranoid -, 81, 228, 231-3, 235, 238, - of persecution, 88, 231, 235-6, 245, - of reference, 56, 224, 228, 231-2, 236, 238, sexual components in -, 235
- Dementia praecox (*see Schizophrenia*), 203, 220
- Denial, 79, 80, 88, 90, 93, 98, 147
- of action, 144, - of genital function, 254-5, 257, 260, - of heterosexual function, 257, - of incest wishes, 258
- Depersonalisation, 225-6, 229, 269
- Depression, 14, 46, 60-1, 74, 96, 116, 119, 133, 137, 168, 174, 183, 187, 190, 204-8, 210-11, 218, 226, 230, 232, 238, 240-1, 260, 283, 288, 300, 304, 321, anxiety -, 248, archaic, 212, catatonic -, 224, - and drug addiction, 245, 247, 249, fixation point in -, 220, 235, hysterical -, 51, 219, manic -, 208, etc., prognosis of -, 311, psychotic -, 219, regression in -, 220, unconscious factors in -, 215, 248, treatment of -, 317
- Depressive, - anger, 49, - character, 265, 269, 311, infantile -, 295, - introjection, 213, paranoid -, 231, 306, - states, 49, 51, 197, 203-4, 206, 207, 215, 245, - suicide, 56, 217, - subgroups, 278
- Dermatosis, 173
- Desexualisation, 78



- Development(al), 30, 54, 59, 65-6, 69, 122, 124-5, 127, 150-1, 160, 165, 167, 174, 176-8, 194, 210, 225, 231, 240, 243, 274, 281, 307  
 - approach to psychoses, 14, 203, 208, 232, 243, - of addiction, 246, character -, 271, - of conscience, 281, child -, 198, 216, 222, 252, 281, 288, ego -, 29, 65, 72, 221, 232, - fixation, 258, 265, infantile -, 22, 28, 30, 58, 97, 106, 153, 160, 175, 208, 239, 255, 257, 261, 281, 294  
 instinctual -, 204, 250, intellectual -, 93, - of introjections, 86, - layers, 96, 208, mental -, 18, 29, 95, 109, 110, 171, 186, 284, 285, - of neurosis, 295, - of paranoia, 231, - phases, 46, 123, 193, pubertal -, 275, - of reality sense, 259, - of self consciousness, 22
- Diarrhoea, 142
- Differential diagnosis, 29, 57, 91, 96, 137, 148, 150-1, 156, 177, 231, 247, 292, 306
- Differentiation, 62  
 - of ego, 29, 58, 62
- Di-phasic symptoms, 119, 245
- Discharge, 16, 17, 98, 159, 187, 197, 200, 209, 222, 233, - affects, 43, 45, 46, 51, disorders of -, 172, - dreams, 187, excitation and -, 171, 181, 184, 212, - of tension, 216
- Disgust, 44
- Disorder(s), alloplastic, - 249, anti-social -, 273, 276, auto-plastic -, 249, behaviouristic -, 278, 295, character -, 51, 263, 268, 270, 275, 277, 309, child -, 31, 294, classification of -, 15, 72, 288, delinquent -, 272, 276, developmental -, 198, - of discharge, 172, ego -, 15, 72, 86, 204, 211, 216, 230, 278, - of excitation, 172, - of feeling, 277, functional -, 170, 178-9, 180, 189, 290, 294, habit -, 277, hormonal -, 172, 175, - of instincts, 172, 199, 204, 207, latency -, 295, marital -, 77, 261, mental -, 13, 14, 16, 23, 28, 30, 46, 69, 72, 89, 96, 120, 123, 130-3, 136-9, 149, 150, 170, 240, 243, 248, 280, 285-7, 299, - of metabolism, 182, muscular -, 175, narcissistic -, 204, 214, 217, 233, neurological -, 148, organic -, 139, 141, 148-9, 173, 284, personality -, 105, psychological -, 172, psycho-sexual -, 77, 250, 265, 274, 277, 289, 308, psycho-somatic -, 101, 139, 170-2, 175, 209, 290, psychogenic sleep -, 13, 139, 286, 299, sexual -, 251, sleep -, 187, social -, 14, 260, 264-6, somatic -, 173-4, speech -, 284, - of temper, 277, vegetative -, 172
- Displacement, 25, 53, 69, 74-5, 81, 89, 90, 104, 113, 126, 129, 145, 147, 151-2, 155, 164, 167, 219, 228, 260, 266, 316, - to animals, 255, - of hostility, 91, 102, - of incest wishes, 258, influence of -, 255, - and sublimation, 78, - and substitution, 77, 78, symbolic -, 193
- Dissociation, 66, 72, ego -, 117, - in time, 166
- Distortion, 112, 126
- Disturbance, bodily -, 47, functional -, 198, instinctual -, 35, 199, - of memory, 72
- Dramatisation, 114, 142-3, 145, 147, 228, 245, 255, hysterical -, 217, - of thought, 141, unconscious -, 197
- Dream, 53, 55, 83, 89, 98-9, 109, 122-3, 186-7, 224, affects in -, 204, analysis of -, 53, 57, 95, 204, - anxiety, 112, 117, 188, - censorship, 113, 115, characteristic -, 200, 303, content of latent -, 88, 112, 115, 116, 208, day -, 52, 55, 89, 293, 303, defences against -, 204, secondary elaboration in -, 88, 114-6, - formation, 80, 112, 115-6, 125, 126, 127, 152, 186, 228, homosexual -, 116-7, - interpretation, 112, 115, 315, manifest content of -, 88, 111-6, 208, - pairs, 116, - product, 109, 110, - puns, 113, repression in -, 72, - states, 116, 143, 147-8, 188, 195, terror -, 187-8, - work, 69, 89, 114-15, 228
- Drug, - addiction, 81, 104, 133, 207, 216, 218, 237, 241, 248, 265-6, 277, fetishism and -, 247, fixation point in -, 248, mental disorders and -, 248, 249, obsessional features in -, 245, - administration, 148, - habits, 248
- Dynamic aspects, - of affective states, 43, - of Id, 63, - of mind, 15-6, 67
- Dyspareunia, 252
- Dyspepsia, 142
- ECHO, - lalia, 226, 229 - praxia, 226, 229
- Economic(s), - of mind, 16, 67
- Eczema, 37, 147, 173, 266
- Efferent, - discharge, 54
- Ego, 22, 26, 38-9, 53, 61, 65, 70, 73, 83, 84, 86, 87, 97, 99, 105-6, 110, 117, 120, 122-3, 126-8, 130-2, 151, 153, 157-9, 165-6, 171-2, 176-7, 179, 180, 210, 213-220, 227, 233, 252, 266, - barrier, 68, body -, 77, 84, 184, 206, 211, 230, 233, - codes, 68, component parts of - 56, conscious -, 57-8, 64, 73, 266, - defenses, 217, - in depression, 203, 206-7, 209, 210-1, 214, 216, 231, development of -, 22,

- 29, 49, 65, 72, 97, 102, 232, 248, 286, disorders of - , 15, 72, 86, 204, 211, 214, 217, 230, 233, 278, - distortion, 241, - differentiation, 28, 57, 62, 82-3, 186, divisions of - , 55, 58-9, 60-1, 63, - energies, 211, - fixation, 83, 221, 230, 234, 274, function of - , 57-8, 65, 67, 159, 200, 216, 238, - and Id, 64, 66, 213, - instincts, 53, 56, - institutions, 47, 68, 252, maniacal - , 206, 226, nuclear theory of - , 65, - nuclei, 65, 184, 186, 211-12, 225, 227, 230, - organisation, 40, 64-6, 69, 81, 82, 106, 185, 186, 192, - phantasies, 60, - regression, 82, 210-11, 217, 224-5, 231, - relations, 56, 152, 316, - responses, 47, 61, 63, 83, 181, 209, - structure, 57-8, 62, 65-6, 73, 79, 96, 186, - in psychosis, 204, 220, 264-5, 277, 319, - and super-ego (see *Super-Ego*), unconscious - , 51, 53, 56-7, 71, 75, 186
- Emotion, 52, 64, 84, 85, 201, 213, 282, Energy, aggressive - , 56, 210, instinctual - , 16, 48, 54, 62, 67, 69, 194, 265, narcissistic - , 226, psychic - , 17, 33, 48, 57, 62, 67-8, 71, 78, 101, 107-8, 122, 124-5, 143-4, 171, 217, sadistic - , 62, withdrawn - , 62, 72, 78
- Enuresis, 147, 180, 187-8, 190
- Epilepsy, 195, affect - , 196, classification of - , 195, 196, genuine - , 196, miniature - , 195, - sub-groups, 278
- Epileptic, aura, 196, - constitution, 196, - equivalent, 195, post - state, 197, - seizures, 101, 194, 218, - syndrome, 195
- Erotism, allo - , 38, anal - , 191, auto - (see *Auto-erotism*), 217, 288, muscle - , 191, 219, oral - 193, 219, 246, respiratory - , 176, 191, skin - , 210, 219, 260, urethral - , 176, 210
- Erogenic zones, 38, 172, 173, 254, 255, 256, 258
- Erotomaniac, - delusion, 235, 237
- Erythrophobia, 155
- Etiology, 35, 152, 154, 157, 163, 170, 175, 177, 183, 221, 225, 231-2, 306, - of alcoholism, 133, - of character peculiarities, 270, classification in terms of - , 141, 189, - of drug addiction, 133, - of neuroses, 35, 158, 208, problems of - , 72, 96, - of psychoses, 35, 208, 220, 240, - of social disorders, 265, - of symptoms, 18
- Euphoria, 206, 218, 246
- Euphoric states, 50
- Evolution, 76
- Excitation, 15, 22, 33, 67-8, 111, 115, 128, 131, 150, 153-4, 159, 162, 164, 174-5, 177, 179, 180-1, 184-5, 189, 194, 209, - and discharge, 65, 171, 172, 174, 182, 184, 188, 212, disorder of - , 172, excessive - , 80, 183, 209, 233, 234, 237, instinctual - , 16, 34, 45, 47, 57, 80, 174, pregenital - , 72, reality - , 228, repressed - , 197, sexual - , 47, 114, 155, 181, 240, unconscious - , 73, unsatisfied - , 71
- Exhibitionism, 37, 146, 154-5, 176, 190, 191, 193, 196, 255-6, 259, 260, 265, 288
- Expiation, 61
- FABRICATION, 90
- Fatigue readiness, 182
- Fear, 22-3, 27, 32, 44, 46, 47, 81, 108, 123, 152, 162, 174, Animistic - , 28, - of animals, 155, - of cancer, 155, castration - , 100, 106, 185, 253, 257, 259, 272, - of cosmic catastrophe, 100, - of the dark, 155, - of death, 155, examination - , 155, - of ghosts, 155, - of loss of love, 49, 63, 275, 291, - of masturbation, 154, persecutory - , 259, punishment - , 153, real - , 27, unconscious - , 76, unreal - , 27
- Fellatio, 146-7, 155
- FERENCZI, 60, 337
- Fetishism, 35, 50, 247, 255, 258-9, 275
- Fixation, 82, 174, 178, 197, 209, 210, 238, 258, 265, 268, 281-2, 319, 320, - addiction, 246, 248, - of body libido, 143, ego - , 210, 230, 274, homosexual - , 39, 183, 193, 236, 262, " - " hysteria, 143, 149, 258, infantile - , 196, 257, 258, - of instinct, 82, - level, 221, 230, 260, narcissistic - 206, oral - , 210, - point, 82, 83, 101, 125-6, 129, 130-1, 193, 209, 220-1, 231-2, 235, 245, 272, 306, pre-genital - 259, urethral - , 271
- Flight, forms of - , 61
- Folie de doute, 159
- FREUD, 13, 14, 15, 30, 33, 36, 45, 50, 52, 53, 54, 56, 57, 58, 63, 65, 68, 70, 71, 72, 79, 83, 84, 87, 109, 113, 117, 118, 139, 147, 148, 153, 165, 166, 172, 173, 180, 189, 194, 198, 203, 207, 209, 222, 225, 227, 228, 235, 237, 238, 240, 250, 254, 271, 280, 303, 305, 306, 324, 328, 329, 331, 333, 335, 336
- Frigidity, 106, 142, 148, 157, 248, 252-3, 261-2
- Frustration, 22, 23, 31, 48, 75, 77-8, 80, 81-3, 91, 94, 97, 110, 114, 124-5, 128-9, 131, 144-5, 153, 159, 163, 172,

- 174-5, 210, 212-4, 219, 233, 268, 282, 284, anal -, 65, anxiety and -, 70, 71, 181, early -, 25-7, 29, 41, 53, imaginary -, 231, infantile -, 216, 256, 281, 282, -instinct, 24-5, 29, 34-5, 44, 46, 48, 55, 62-5, 67, 78, 80-1, 85, 216, 294, oral -, 65, 84, 97, 209, preconscious -, 88, sensitiveness to -, 295
- Fugues, 72
- Fusion, - of infantile sexuality, 60
- GAIN, primary -, 128, 136, 312, secondary -, 128, 132, 136, 143, 157, 180, 313, 329
- Gastro-intestinal, system, 97, - disturbances, 47
- Genital, 59, 60, 66, 97, 105, 129, 132, 145, 147, 153-7, 175-6, 191, 217, 293 adult -, 59, - character formation, 271, - guilt, 60, infantile -, 72, 76, 145-6, 190, 193, 211, 306, - injury, 103, 291, - interests, 66, 101-2, 207, 255, - libido, 259, - masturbation, 102, - Oedipus situation, 59, 84, 100, - punishment, 60, 61, - sadism, 41, - super-ego, 60, - zone, 35
- Gratification, 18, 37-8, 44, 64, 68, 74, 77, 80, 82, 91, 97, 98, 99, 101, 110, 115-6, 124-6, 129, 131, 144, 146, 154, 165, 181, 254, 282, 284, 288, anal -, 65, excessive -, 82, 282, - and frustration, 212, - of impulses, 40, 43-4, 48, 56, 59, 65, 67, 73, - of incestuous impulses, 37, 49, instinctual -, 55, 80, 85, 209, 282, perverted -, 255, reality -, 228, substitute -, 23, 25, 29, 67, unconscious -, 36
- Grief and mourning, 205
- Guilt, 23, 44, 48, 103, 119, 126, 127, 158, 162-3, 167, 174, 185, 216, 218, 223, 257, 326, absence of -, 278, aggressive -, 218, - and anxiety, 31, 47, 49, 71-2, 76, 94, 190, 294, depressive -, 214, genital -, 60, 218, 246, 252, 285, masturbatory -, 193, - mechanisms, 103, origin of -, 23, 27, - psychosis, 49, 61, 204, 218-9, unconscious -, 46, 49, 117, 119, 147, 173-4, 180, 183, 238, 246-7, 254, 260, 266, 276
- HALLUCINATION, 53, 80, 88-9, 92, 94, 114-6, 142, 147, 156, 186, 204, 210, 224, 228, 232, 235, 242-3, stereotyped -, 196, - formation, 231
- Hallucinatory, 226, - products, 228, 235, - regression, 233
- Hate, 24, 53, 56, 60, 62-3, 163, 165, 174-5, 252, 256, 258, love and -, 25, 32, 60, 62, 73, 78, 212, 245-6, sadism and -, 212, secondary -, 47, self -, 63, 207
- Headaches, 142-147
- Hebephrenia, 220 (*see also Schizophrenia*)
- Heterosexual, - inhibition, 247, - intercourse, 252, - objects, 39
- Heterosexuality, 46, 163, 236-7
- Homicidal, - attack, 216, - tendencies, 228
- Homosexual(ity), 107, 145, 147-8, 156, 163, 165, 167, 179, 191, 193, 210, 228, 235, 238, 253, 256, 257, 260, 265, 304, - attachment, 105, 236, 238, 258, - attitudes, 106, 196, 267, - characteristics, 39, conscious -, 237, - dreams, 116-7, - ego-nucleus, 239, - fixation, 39, 183, 210, 236, 246, 257, 262, 272, - intercourse, 160, - libido, 223, 229, 240, male and female -, 87, 258, unconscious -, 46, 119, 120, 133, 148, 175, 178, 223, 237, 239, 240, 247-8, 253, 259, 261-2, 276
- HORNEY, 333
- Hunger, 34, 98, 187
- Hyperacusis, 142
- Hyper-sensitiveness, 56, 182, 208
- Hypersomnia, 188
- Hypertension, 176
- Hypertonus, 175
- Hypnosis, 197, 199, 200
- Hypochondria, 37, 86, 168, 170, 175, 177, 180, 182, 183, 184, 185, 187, 191, 195, 200, 206, 210, 218, 225, 226, 229, 235, 236, 248, 271, 278
- Hypomotility, 181
- Hypotonus, 175, 182
- Hysteria(cal), 13, 35, 49, 72, 76, 128, 129, 137, 139, 140, 141, 144, 146, 147, 153, 156, 160, 168, 170, 174, 175, 190, 249, 262, 267-8, 294, 304, 306-7
- Anxiety -, 106, 139, 148, 149, 151, 153, 157, 159, 163, 181, 193, 223, 300, 309, 320, - character, 74, 132, 219, 268
- Conversion -, 13, 35, 42, 50, 86, 88, 106, 116, 117, 129, 139, 140, 145-9, 151, 153, 157, 159, 162, 164, 166, 168, 170, 181, 183, 190, 193, 195, 245, 266, 290, 309, 310, 321, " - ", delinquency, 274, 275, - depression, 51, - fixation, 143, 149, 258, - formations, 64, 89, 106, 165, - fugues, 26, 72, - hallucinations, 142, 143, 147, - mimicry, 87, monosymptomatic -, 309, - narcolepsies, 195, - neuralgias, 142, organ -, 142, - phobias, 233, 240, pre-genital -, 193, pseudo -, 268, - repression,

- 74, - seizures, 197, - subgroups, 278, - suicide, 217, treatment of -, 317
- ID, 68, 64, 65-6, 68, 80, 82, 111, 126-7, 166, 213, ego and -, 64, 66, 82, - tension, 224, 229
- Idea(s), 52, 71, 75, 114, 152, 160, 166, delusional -, 226, fixed -, 160, flight of -, 224, obsessional -, 156, realistic -, 88, - of reference, 224, 230, 234, unconscious -, 146
- Ideation(al), 43, 51, 64-5, 76, 140, 145, 149, 150, 159, 232, - activity, 102, 117, - and affect, 54, 75, 171, - association, 166, - presentation, 64, 93, 204, primitive -, 93
- Identification, 25, 76, 83, 87, 96, 99, 103, 106, 114, 144-7, 210, 213, 215, 258, 261, 271, 284, displacement and - 76, introjection and -, 86, narcissistic -, 119, 210, - with parents, 62, 84, 87, origin of -, 87, systems of -, 86
- Illusion formation, 88
- Image(s), 43-4, 54, 62, 73, 85, affect and -, 55, genital -, 185, visual -, 80, 98, 160, 192
- Imago, 55, 84-7, 93, 130, 184, 219, introjection of -, 85, mother -, 261, object -, 55, 84, parental -, 49, 100, 214
- Impotence, 106, 142, 148, 157, 180, 239, 248, 253, 261-3, 270, 307
- Impulse(s), 33-5, 48, 62, 66, 68, 77, 100-2, 104-5, 125, 130, 144, 149, 153, 163, 193, 227, aggressive -, 30, 34, 37, 41, 44, 58, 162, 189, 191-2, 246, classification of -, 41, asocial -, 27, autoerotic -, 48, frustrated -, 24, 26, 44, 48, genital -, 193, 306, 313, gratification of -, 44, 56, 73, incestuous -, 30, 37, introversion of -, 27, love -, 34, 165, masochistic -, 33, oral -, 33, 193, passive -, 42, pilot -, 69, primitive -, 44, 48, self-preservative -, 34, 44, sexual -, 30, 34, 41, 43, 92, 196, 204, trigger -, 144, unconscious -, 92, viewing -, 191
- Incest, 60, 160, 165
- Incestuous, - anxiety, 253, 259, - conflict, 293, - crime, 188, - intercourse, 154, 228, 252, - objects, 38, - phase, 30, - taboo, 22, - wishes, 30, 37, 61, 62, 63, 251, 256-7, 258
- Inertia, 61
- Infancy (see also *Childhood*) 122-3, 129, 130, 132, 145, 147, 153, 160, 164-6, 172, 174, 179, 193, 226, 240, 267, 282-3, 294, 303
- Infantile, - aggression, 58, - development, 22, 58, 101, 102, 208, - fixation, 178, 257, - frustration, 282, - genital, 59, 72, 78, 146, 165, 193, 211, 306, - gratification, 282, - obsession, 259, - sexual components, 38, 77, 193, - sexual interests, 35, 38, 60, 197, - sexual theory, 36, 37, 154, 256, 267, - sexuality (see *Sexuality*), 85
- Infantilism, 196
- Inferiority, - feeling, 46, 49, 266
- Inhibition, 26, 49, 67, 99, 104, 115, 119, 123, 131-3, 136, 140, 173-4, 177-9, 180, 185, 192-4, 252-3, 261, 267-8, 283, 285, 290, 293-4 - of action, 160, aim -, 76, 166, defensive -, 277, depth of -, 253, functional -, 142, 209, ideational -, 206, instinctual -, 44, 60, 93, 144, neurotic -, 41, 240, obsessional -, 266, 267, precocious -, 286, psychosexual -, 292, 311, 321, psychotic, 41, 240, self -, 26, 74, sexual -, 41-2, 249, 250-1, 252, 254, 270, social -, 56, 266, 270, 311, 321, - of thinking, 93
- Insomnia, 83, 111, 187, 246,
- Instinct, 26, 38, 45, 53-5, 60, 64, 73-4, 77-9, 97, 98, 122, 124-5, 137, 140, 144, 149, 150, 159, 162, 171-5, 186, 191, 228, 281, 282, adult sexual -, 85, aggressive sexual -, 35, 40, 41-3, 48, 73, 92, 93, 221, 250, aim of -, 33, 67-8, 74, 75, 82, antithetical -, 46, 48, - cathexis, 71, 76, classification of -, 33, components of -, 35, 45-6, 65, 81-2, 173, 238, - crisis, 120, 140, 187, - derivatives, 50, 58, 64, 69, 76, 204, discharge of -, 45, 68, disorders of -, 207, 281, ego -, 53, 56, - energy, 16, 53-4, 62, 77-8, 143, 265, - excitation, 16, 43, 46, 83, 97, 111, 209, 233, - fixation, 82, frustration of -, 29, 31, 34, 82, fusion of -, 50, - gratification, 65, 67, 74, 208, - groups, 34, 60, - inhibition, 27, 60, 67, introversion of -, 209, lability of -, 125, mastery of -, 29, 60, 65, 144, 186, 230, 281, object of -, 33, 74-5, 84, 212, 242, primacy of -, 65-6, 97, primitive -, 22, 47, 53, 60, - reflection, 79, regression of -, 123, reversal of -, 79, 216-7, sadistic -, 63, self-preservative -, 34, 46, 47, sexual -, 84, sources of -, 33, 75
- Intellectual, - activity, 41, 75, 92, 93-4, 115, - apprehension, 294, - development, 93
- Intelligence, - tests, 94
- Interest, 52, 56, 71, 75, 125, 132, 206, 225, aesthetic -, 78, anal -, 73, excretory -, 60, genital -, 60, 76, 234, introversion of -, 89, 124, oral -, 75, primitive -, 44, - in prostitutes, 236

- Introjection, 25, 83, 84-7, 93-4, 99, 100, 102, 105-6, 210, 212, 215, 220, 238-9, 241, 261, 271, depressive -, 213, 218, -and incorporation, 212, -mechanism, 38, 62, 72, 211, -of objects, 212, pathological -, 212, 213-4, 220, 226, 230, -phantasies, 86, primary -, 95, 214, projection and -, 83, " -" psychosis -, 220, traumatic -, 211
- Introspection, 57, 70, 72
- Introversion, 47, 83, 90-1, 124, 131, 144, 145, 153, 185, 290, depressive -, 209, instinctual -, 27, 209, 213, -of libido, 285, neurotic -, 184, 209, pathological -, 93
- Irritability, 35
- JEALOUSY, 46, 49, 118-9, 239, 329, delusional -, 235, 262, -of parents, 30
- JUNG, 13, 83, 333
- KLANG ASSOCIATION, 228, kleptomania, 163, 275
- KRAEPELIN, 234
- KRAFFT-EBING, 234
- LATENCY, 34, 73, 106-7, 286, 289, 293, -disorders, 295, -manifestations, 294
- Libido, 34, 38-9, 40, 91, 125-6, 128, 129, 130-1, 143-4, 153, 165, 173, 175-7, 181, 184, 259, 260, 285, body -, 34, 85, 37, 42, 184, -development, 84, 96, homosexual -, 210, 223, 229, 238, 246, incestuous -, 63, infantile genital -, 72, 78, object -, 39, 184, 209, oral -, 209, organ -, 34-5, 38, 175, 177, 184, 230, -weakness, 234, withdrawal of -, 56, 209
- Love, 24, 26, 34, 46, 48, 53, 56, 60, 77, 79, 84-5, 87, 124, 157, 163, 165-8, 191, 213-4, 253, 257, 260, 275, 295, -and hate, 45, 60, 62-3, 73, 78, 105, 114, 175, 212, 245, heterosexual -, 257, homosexual -, 238, 257, -objects, 44-6, 81, 125, 145, 179, 247 sadistic -, 253
- Lying, phantastic -, 90
- MAGIC, 164
- Maladaptation, 18, 22, 49, 107, 120, 140
- Maladjustment, 39, 252, pubertal -, 274, sexual -, 261
- Malingering, 157
- Mania, 132, 203, etc., 218, 224, 241, depressive factors in -, 205, excitement in -, 245, hyperactivity in -, 226, object cathexis in -, 218, phases in -, 207, 236, pleasure affect in -, 50, regression in -, 218, 220, 241, religious -, 225
- Manic depression, 101, 130, 160, 169, 203, etc., 220, 223, 224, 225, 226, 230, 232, 244, ego in -, 214, etiology of -, 208, obsessional characteristics in -, 204, personality in -, 205, super-ego in -, 214, types of -, 269, unconscious factors in -, 205
- Mannerism, 120, 190, muscular -, 195, schizophrenic -, 227, 229
- Marital, -difficulties, 260, 261, 270, -relations, 261, 269
- Masochism, 37, 40, 42, 80, 178-9, 210, 248, 255-6, 267, 275, 276, aims of, 288, anal -, 42, 256, crisis of -, 249, excess of -, 208, 219, depression and -, 214, 216, 248, 249, genital -, 42, 256, hysterical -, 262, moral -, 42, 63, oral -, 42, 256, primary -, 42, 45, 95, 98, 216, sado -, 79, 210, 217, 255, 269, secondary -, 42, 45, -tic types, 50, 119
- Masturbation, 38, 107-8, 146, 147, 155, 163, 165, 188, 229, 257-9, 260, 282, 288, 289, anal -, 293, compulsive -, 38, 50, 183, 252, 285, -equivalent, 191, excessive -, 35, genital -, 38, 102, -guilt, 193, -impulse, 73, 154, 166-7, 252, 254, 259, 267, 291
- Mechanism, 14, 16, 29, 61, 67-9, 72, 76, 79, 80, 91, 95, 97, 122-3, 152, 164, 166, 170, 177, 194, 209, 240, 270, 308, -of character formation, 294, -of condensation, 228, convulsive -, 101, defence -, 69, 92, 98, 115-6, 181, -of displacement, 228, flight -, 73, -of functional neurosis, 224, 278, -of introjection, 38, 220, 241, 270, -of narcissism, 46, -of projection, 220, 241, 269, 270, -of psychosis, 224, 236, 278, repression -, 72-3, 90, 241, schizophrenic -, 278, -of sublimation, 78, -of symbolism, 228, -of symptom-formation, 209
- Megalomania, 39, 56, 206, 226
- Melancholia, 96, 131, 183, 187, 203, 204, 205, 207, 210, 219, 224, 241, 245, 249, involuntal -, 219, regression in -, 240, stupor in -, 211
- Memory, 147, 157, accessible -, 52, cover -, 147, disturbance of -, 72, 83, 118, 143, interpretation of -, 110, lapses of -, 72, 117-19, recovery of -, 72, -traces, 54-5, 64-5, 72, 75, 82, 84, 97, 98, 100, 185
- Menopause, 219
- Mental activity, 57, 59, 63-4, 67-9, 70, 76-7, 82, 117, 122, 131, 149, 158, 162, 170-1, 176, 182, -apparatus, 54, 51-58, 63, 111, 299, -breakdown, 35, 67, -conflict, 43, 250, 299, -defect, 94, 283, -development, 18, 22, 95,

- etc., 109, 186, 198, - disorders, 16, 46, 66, 69, 72, 89, 139, 149, 150, 248, 280, 285, 287-8, - dynamics, 96, - economics, 92, 96, 109, - function, 14, 51, 57, 67, 192, 202, 208, 299, - health, 92, - measurements, 94, 274, mechanism, 53, 67, 69, 76, 79, 174, - topography, 17
- Metabolism, 182
- Metaphysician, 91
- Metapsychology, 15-6, 53, 92, 117, 122, 220, 264
- Migraine, 147
- Mind, 67-8, 83, 123, 171, - and consciousness, 52, division of - , 52, 59, 60, 96, dynamic aspects of - , 38, 95, economics of - , 67, 95, function of - , 15, 53, 65, 67, structure of - , 51, 53, 68, 95, unconscious - , 23, 33, 51-2, 57, 123, 144
- Moral, - imbecibility, 277, - masochism, 63, - rumination, 61, 63, - systems, 61
- Morality, primitive - , 61
- Morphine, - addiction, 244, 247
- Motive, 33, 118, - for adaptation, 49, conscious - , 57, - in delinquency, 243, unconscious - , 88
- Motor, - discharge, 131, - disturbances, 141, 173, - end of psychic apparatus, 15, 16, 54, 67, 80, 148, - manifestations, 141, 146, 184, psycho-activity, 206, 210, - skill, 131, - system, 194
- Muscle, - erotism, 191, - mannerism, 195
- Muscular, - activity, 191, - disturbances, 47, neuro - , 192, voluntary - system, 195
- Musculature, 39, 41
- Mutilation, 60, 114, 116, 153, genital - , 259, 260
- Mutism, 147, catatonic - , 193, 226, 227, hysterical - , 193
- NARCISSISM, 38, 44, 98, 130, 143, 162, 175, 177, 184, 190, 196, 201, 206, 210, 212, 215, 226, 235, 241, 257, 259, 262, - and homosexuality, 257, primary - , 38, 39, 63, 80, 95, 216, 284, secondary - , 38-9, 230
- Narcissistic, - breakdown, 242, - defences, 206, 234, - ego, 47, 63, 78, 179, 204, 214, 218, - fixation, 206, - identification, 119, 210, - organisation, 46, 79, 86, 220, - phobia, 151, - regression, 80, 208-9, 211, 214, 223, 225, 235, 238
- Narcolepsy, 148, 195
- Negativism, 90, 94, 178, 226, 300
- Neologism, compulsive - , 160, - in dreams, 113, 118, 160, syllabic - , 193
- Neurasthenia, 139, 170, 177, 180-3, 187, 194, 198, 200
- Neurological disorders, 148
- Neurologist, 194
- Neuroses, 14, 16, 22, 35, 56, 100, 110, 124-9, 130, 147-8, 153-4, 159, 162-8, 170, 181, 190, 193, 198, 209, 243, 249, 254, 257, 270, 291, 294, 299, 307, 310, accident - , 179, adult - , 14, 125, 148, 295, anxiety - , (see anxiety neurosis), compensation - , 180, depressive states in - , 203, etiology of - , 35, evacuation - , 180, exhaustion - , 139, gastric - , 13, guilt - , 49, 50, 163, 204, 219, 264, infantile - , 14, 83, 125, 148, 290, mono-phasic - , 129, mixed - , 307, narcissistic - , 203-4, 264, nuclear complex of - , 37, 147, obsessional - (see obsessional neurosis) prognosis of - , 309, organ - , 173-5, 182-3, 185, 195, 198, 200, - and epilepsy, 195, 209, patho - , 170, 177, symptoms of - , 48, 53, 61, 105, 115-6, 159, 161, 165, 168, 189, skin - , 176, transference - , 86, 87, 140, 200-1, 316-7, 329, 333-4, traumatic - , 176, 178, 180-190, 195, 197, 198, 200, 206, 209, 218, 222, 224, 240, treatment of - , 317, war - , 178-9, 240
- Neurogenesis, 250, 303
- Nomenclature, 49, 57
- Nuclear, - body ego, 184, - complex, 37, 147, 233, - development, 96, 232, - theory of the ego, 65, 66
- Nucleus, anal - , 65, anal sadistic - , 239, body - , 184, ego - 65, 82-3, 186, homosexual - , 239, oral - , 60, 65, 239, skin - , 184, super-ego - , 60, 72, 285
- OBJECT, 47, 49, 56, 60, 62, 65, 67, 78, 81, 84-6, 99, 102-7, 144, 151, 155, 160, 162, 165, 213, 220, 226-7, 229, anal - , 174, - cathexis, 80, 207, 223, - formation, 97, 184, 284, frustrating - , 214-5, 233, - imago, 84, instinctual - , 55, 74-5, 212, introjected - , 215, - libido, 39, 46, 78, 185, 249, - loss, 46, 174, 213-5, 220, 242, 249, oral - , 174, parental - , 60, 214, 215, "part - ", 99, - relations, 39, 50, 55-6, 74-5, 78, 85, 86, 152, 164-5, 174, 204, 206, 209-10, 211, 213, 215, 220, 225, 227, 229, 233, 249
- Obsolescence, 24
- Obsession, 51, 61, 136, 156, 159, 161-169, 193, 244, 249, 270, 275, 283, 291, 306, 310, 321, - and addiction, 245, depressive - , 306, infantile - , 259

- Obsessional, - action, 86, 119, 158, 161-2, 167, 219, 275, - character, 132, 269, - inhibition, 266, - neurosis, 49, 61, 73-4, 88, 127, 129, 130, 157, 166, 173, 183, 208, 245, pre-, 160, - ritual, 22, 75, 158, 190, - rumination, 158, sub-groups, 278, - symptom, 75, 79, 204, 245, 260, 265, 294, - thinking, 94, 160, - types, 74, 117, - washing, 159, - word play, 161
- Oedipus, - complex, 37, 58, 100, 105, 145-7, 153-5, 230, 286, homosexual aspect of-, 147, - nucleus, 248, - phase, 36, 58-9, 105-6, 129, 145, 165 - situation, 59, 60, 63, 85, 100, 105, 237, 248, 258, - wish, 36, 94, 259
- Olfactory system, 54
- Omnipotence, 206-7, 226, - of thoughts, 228
- Oral, - character formation, 271, 272, - ego-nucleus, 65, - erotism, 66, 84, 97, 174-5, 193, 209, 212, 219, 246, - frustration, 65, 210, - gratification, 65, 101, - incorporation, 84, - love, 60, 209, - phantasies, 91, 217, - primacy, 36, 65, 97-8, 100, - punishment, 60, - regression, 155, - sadism, 41, 59, 80, 84, 98, 101-2, 104, 197, 204, 209, 217, 239, 246, 260, - stage, 36, 106, - super-ego nucleus, 60, - zones, 35, 42, 155, 255
- Organic, - disease, 139, 141, 173, 177
- Orgasm, 154-5, 188, 197, 252, 254, 256, 260, auto-erotic -, 217
- Orientation, 83
- Over-determination, 126
- PAIN, - experiences, 45, 48, psychic -, 174
- Panic, 47, 150
- Paraesthesia, 141, 182
- Paralysis, 141, 170
- Paranoia, 53, 81, 100, 130, 203, 208, 218, 220, 225, 231, etc., 237, 240, 241, 249, clinical entity of-, 231, delusional products of-, 235, development of-, 231, etiology of-, 232, fixation point in-, 220, homosexuality and-, 236, litigious-, 238, projection in-, 276, regression in-, 240, schizophrenia and-, 231
- Paranoid, - addiction, 245, 247, - character, 132, 197, 224, 234, 269, 308, - crisis, 219, - delinquent, 276, - delusion, 233, 238, 260, - epilepsy, 196, - psychosis, 230, 231, 239, - states, 49, 168, 219, 231-4, 238, 240, 241, 306, 307, - sub-groups, 278
- Paraphrenia (see also *Schizophrenia*), 96, 183, 220, 239
- Paresis, 141, 145
- Parent, 26, 44, 49, 62, 85, 98, 114, 146, 155, 188, 191, 246, 271, 302, - and aim inhibition, 108, ambivalence to-, 167, analysis of-, 296, conflict between-s, 215, 287, identification with-s, 105, jealousy of-s, 30, 267, relation to-s, 261, 267, 292, - and sexuality, 63, 76, 84, 145, 147, 217, 253
- Parental, - coitus, 155, 197, 303, - hate, 62, 215, 238, - love, 30, 43, 285, 286, 287, 295, - objects, 60, 62, 75, 86, 87, 103, 105-6, 155, 166, 214-5, 245, 256
- Patho-neurosis, 170, 177
- Pavor nocturnus, 187
- Penis envy, 211
- Perception, 88, 118
- Perceptual, - consciousness, 90, 114
- Personality, 58, 105, 136, 156, 167, 169, 299, 334, - disorder, 105, 278, function of-, 16, 250, psycho-pathic-, 276, - reaction, 267, types of-, 96
- Perversion(s), 35, 41, 87, 131, 133, 137, 140, 250-3, 256-8, 260, 266, 269, 277-8, 299, 302, 307, 308, 310-11, classification of-s, 260, - and drug addiction, 249, - formation, 293, object of-, 50, phantasies of-, 252-4, prognosis of-, 311, psycho-sexual-, 292, sadistic and masochistic-, 41, 43, 252, 255, 260, sexual-, 254, 274, 278, classification of- 2, 254, treatment of-, 312, 321
- Phallic, - phantasies, 193-4, - phase, 36, - symbolism, 246, 256
- Phantasy, 36, 38, 89, 91, 103-4, 114, 124, 144, 146-7, 162, 194, 209, anal and oral-, 91, 206, anal-sadistic-, 60, 64, 65, animistic-, 218, 225, cannibalistic-, 210, coprophagic-, 260, coprophilic-, 260, - formation, 83, 93, 144, hysterical-, 143, impregnation-, 61, 146, 154, 157, 167, 194, incestuous-, 146, 155-6, 165, 167, 267, - interpretation, 315, mutilation-, 258, perverse-, 252, 254-5, - thinking, 52, 53, 83, 92, 93, unconscious-, 31, 36, 38, 46, 72, 86, 90-1, 102, 103, 107, 113, 125, 129, 140, 144, 145, 147, 155-6, 160-1, 164-5, 167, 188, 194, 245, 255, 259, 267, 294, 303
- Phobia, 44, 45, 47, 102-3, 105, 129, 140, 151, 153-160, 163-4, 168-9, 175, 247, 267, 283, 306, 320, adolescent-, 151, anxiety-, 179, - of blindness, 175, contamination-, 259, 266, ereuto-, 266, food-, 155, - formation, 76, 81, 144, 165, 181, 291, 301, foun-

- dation of - , 60, hysterical - , 156, 233, 265, infantile - , 155, 233, latency - , 151, middle-age - , 151, monosymptomatic - , 76, 154, narcissistic - , 151, - object, 157, obsessional - , 156, paranoid - , 156, 237, 306, pre-genital - , 156, pubertal - , 151, - of sleep, 188, speech - , 193, - of venereal disease, 239  
 Play, 103, - association, 295, free - , 285  
 Pleasure, 44-5, 48, 83-4, 89, 125, 283, - affect, 45, 50, corporal - , 98, fore - , 35, 253, - and pain, 31, 45, 192, 211, - principle, 16, 48, - tone, 44, 98  
 Pleasure/pain, 79, 80, 86, 186, 212, 283, 284  
 Potency, 194  
 Precipitating, - factor, 123-4  
 Pre-conscious, 64, 68-9, 70, 75, 87, 89, 118, 125-6, 130, 131, 144, 192, - cathexis, 72, 76, - elements, 92, 123, - function, 87, 90, 92, - system, 52-3, 55, 64, 71, 73, 75, 79, 102, 104, 109, 290, - and unconscious, 68, 71  
 Pre-disposition, 128  
 Pregenital, 59, 155-6, 165, 167, 175-6, 179, 183, 188, 190, 217, 239, 245-6, 248, 253, 259, 275, 306  
 Pregnancy, 147, bowel - , 146, incestuous - , 167, pseudo - , 142  
 Presentation, ideational - , 93, phantasy - , 144, power - , 52-3, psychic - , 56, 69, 92, somatic - , 141, symbolic - , 114, 'thing - ', 102, 228, visual - , 113-14, 'word - ', 228  
 PRICHARD, 277  
 Primary Processes, 53, 68-9  
 Prognosis, 51, 96, 109, 116-7, 128, 136, 158, 168, 169, 281, 294, 303-7, 308, 334, - of delinquency, 311, - of drug addiction, 247, 311, error in - , 282, - of hysteria, 309, - of mania, 205, - of marital disorders, 263, 311, - of obsessional neurosis, 310, - of psychoneurosis, 198, 299, 309, 310, - of psychosis, 310, - of sexual disorders, 251-2, 311, - of social inhibition, 268, 311  
 Projection, 53, 62, 72, 80, 86, 90, 93-4, 99, 102, 126, 130, 152, 155, 220, 230, 233-4, 241, 245-6, 265, 291, - anxiety, 253, - in mania 218, paranoid - , 233, 235-6, 276, primary - , 95, 233, - psychosis, 220  
 Prophylaxis, 136  
 Prostitution, 263  
 Pseudologia phantastica, 90, 293  
 Psychasthenia, 139  
 Psychiatry, 329, training in - , 202  
 Psychiatrist, descriptive - , 236  
 Psychic activity, 82, 123, 150, 164, 170-1, 174, - content, 141, 162, 170, 177, 211, 222, - continuity, 66, 75, 92, - energy, 33, 57, 68, 181, - function, 44, 51, 55-7, 64, 110, - mechanism, 66-8, 79, 96, 97, - products, 52, 58, 59, - stress, 178, 196, 301, - structure, 51, 52, - systems, 36, 52, 63, 65, 72, 126, 194  
 Psychoanalysis, 13, 17, 95, 122, 136-8, 140, 156, 165, 183, 199, 200, 222, 237, 248, 264, 309, 310, 313-4, 319, 322, - of adults, 295, 296, - approach to psychoses, 84, 202-3, 214-15, 217, 220, 240, 242, 256, basic concepts of - , 67, 100, - of children, 84, 232, 280, etc., 295, 296, 318, 329, 335, classification in - , 264, cost of - , 322, - and development, 243, duration of - , 319, group - , 335, hypno - , 337, interpretation in - , 120, 227, 309, 315, 334, narco - , 337, nature of - , 280, - observation, 14-15, 30, 58, 84, 95, 137, 194, 196-8, 202, 248, 257, 296, 310, 311, probationary - , 198, 312, 321,  
 Psychoanalyst, 16, 58, 89, 96, 119, 140, 190, 194, 208-9, 222, 231-2, 237, 242-3, 271, 280, 286-7, 302-4, 312, 314-15, 324-6, amateur - , 88, choice of of - , 323, etc., lay - , 328, parental figures and - , 75  
 Psychoanalytical, - pedagogy, 295, - practice, 28, 55, 136, - prognosis, 198, - reconstruction, 95, - resistance, 136, - survey, 231, - technique, 30, 55, 57, 280, 324, - treatment, 17, 68, 75, 119, 136, 202, 263, 281, 314, 333  
 Psycho-genic, - disorders, 139, 170, 175, - factors, 174, 179, 184, 188, 274, - pre-disposition, 222  
 Psychological, - examination, 148, 248, 304, - mishandling, 294, - treatment, 275  
 Psychologist, 70, 108, 333, child - , 209, 288, 292, clinical - , 22, 69, 88, 92, 139, 251, 273, 'conscious' - 92, descriptive - , 93, 257, mensurational - , 89, 'unconscious' - , 92  
 Psychology, 95, 97, 253, depth - , 305, descriptive - , 122, dynamic - , 33, individual - , 273, meta - , 15, 16, 53, 92, 117, 122, 220, 264, type - 307,  
 Psycho-neuroses, 13-5, 49, 62, 101, 126, 128, 130, 131-189, 140, 144, 149, 150, 157, 168, 170-3, 176-7, 180-2, 185-7, 189, 192, 194, 200, 222, 224, 236, 241,



- 252, 260, 290, 291, 300-1, conflict in -, 208, etiology of -, 139, infantile -, 290, libido in -, 209, mixed types of -, 168, 189, 192, prognosis of -, 309, reaction formation in -, 74, symptom formation in -, 209, 233, 236, 244, traumatic -, 176, 218
- Psycho-neurotic, - mechanism, 278, - repetition, 181, - symptoms, 45, 141, 179, 181, 185, 186, 188, 196, 197, 198, 240, 251, 266, - type, 274
- Psychopathic, 163, 244, 260, 270, - delinquent, 216, 274, - reaction, 209, - type, 49, 105
- Psychopathy, 89, 133, 204, 222, 250, 264, 276-9, 294, 307
- Psycho-pathology, 13, 51, 108, 189, 199, 225, 264, - of everyday life, 117
- Psychosexual, - abnormalities, 250, 253, 277, - activity, 288, - constitution, 262, - development, 15, - disorders, 250-2, 263, 265-6, 288-9, 308, 315, - function, 178, 261, - history, 301, - inhibition, 290, 292, - instincts, 281-2, - interest, 36, - offences, 256, - relations, 261, 301, 310
- Psychosis, 13-4, 35, 83, 100, 105, 130-2, 137-9, 156, 168-9, 170, 178-9, 180, 183, 186-7, 189, 192, 194, 202, 209, 218, 220, 222-4, 231-6, 238-9, 240, 242, 245, 248-9, 250, 252, 257, 277, 290, 292, 294, 301, 306, 308, 310, 321, affect -, 204, classification of -, 203, 240, clinical forms of -, 240, climacteric -, 96, development of -, 203, 240, ego -, 209, etiology of - 35, 208, 240, guilt -, 49, 61, 204, 218, 'introjective' -, 220, manic-depressive -, (*see also Depression, Mania, Manic-Depression*), 86, 160, 188, 203, 209, 220, narcissistic -, 204, 'oral-sadistic' -, 204, prodromal symptoms of -, 203, prognosis of -, 309, 310, 'projective' - 220, 240, psychoanalysis and -, 202, super ego in -, 209, traumatic -, 211, 216, 227, 231
- Psycho-somatic disorders, 101, 139, 140-1, 170-9, 184, 186, 188, 189, 195, 197-8, 201, 209, 212, 240, 290, - specialist, 201, treatment of -, 198
- Psycho-therapy, 13, 136, 175, 198, 200, forms of -, 199, 334, - of psychosis, 242
- Psychotic, - behaviour, 221, - breakdown, 39, 56, 116, 124, 169, 203, - defences, 253, - delinquent, 276-7, - disposition, 209, 294, - hypochondriasis, 103, 185, - mechanism, 258, 278, - pre-mechanism, 258, 276, 291, - stupor, 188, - symptoms, 45, 49, 53, 117, 184, 202-4, 209, 218, 240, 242, 250, 266, - types, 202, 203, 274
- Puberty, 34, 77, 106, 107, 108, 123, 151, 176, 263, 275, 281, 294
- Punishment, 27, 36, 49, 61, 130, 146, 153-4, 164, 166, 194, 216, 236, 276, 291, 294, depressive -, 218, fear of -, 60, 153, super-ego -, 61, 217, unconscious need of -, 42
- QUERULANCE, 132
- RAGE, 24, 49, 207
- RANK, 333
- Rationalisation, 28, 87-8, 115, symbolism and -, 69
- Reaction-formation, 73-4, 87, 90-1, 103-5, 164, 219, 238
- Reality, 123, 130, - adaptation, 28, 52, 287, 303, - ego, 241, - excitation, 228, - experience, 89, - falsification, 91, - function, 242, - gratification, 228, - principle, 48, - proving, 221, 242, 266, 289, 292, 300, - relation, 28, 204, - sense, 28, 92, 99, 186, 232, 234, 243, 278, 280, - system, 49, - thinking, 31, 89
- Reflex, - action, 191, - arc, 15, 54, simple and conditioned -, 48
- Reflexion, 80, 98, 216-8, - in sado-masochism, 79
- Regression, 39, 66, 76, 82-3, 96, 98-9, 102, 105-6, 110, 116, 123, 125, 126, 130-2, 144, 165-6, 171, 177, 180-186, 196, 209, 213, 216, anal-sadistic -, 156, character -, 51, 83, defensive -, 156, 216, 293, - and depression, 220, depth of -, 209, - in dreams, 110, ego -, 66, 82, 231, hallucinatory -, 233, - of libido, 83, 214, - in mania, 218, narcissistic -, 209, 211, 235, 238, oral -, 156, paranoid -, 238, 240, - products, 225, 227, 228, - and repression, 72, - in sleep, 70, 82, 111, schizophrenic -, 179, 221-3, 236, stimulus to -, 212
- Rehabilitation, 200
- Remission, 244
- Representation, bodily -, 140, indirect -, 114, symbolic -, 165, verbal -, 71
- Repression, 24, 52-3, 64, 70, 72-5, 81, 86, 87, 96, 102, 105, 112, 115-6, 127, 144-146, 153-156, 160, 162, 164-5, 174, 178, 181, 197, 223-226, 258, 267, - of anal interest, 73, - barrier, 53, 57, 71, 90, 126, cathexes in -, 74, content of -, 70, 141, development of -, 79, faulty -, 79, 223, 256, 290, function of -, 69, 72, 93, - in hysteria, 73, mechanism of -, 57, 73,

part -, 166, primary -, 71, 72, 79, 80, 90, 95, projection and -, 81, repressing and -, 73, 74, 115, 116, 127, 162, 174, 223, 233, return of repressed, 290, sublimation and -, 77  
 Respiratory, -disturbances, 47, -elements, 193, -system, 48  
 Restitution, 221  
 Reversal of instinct, 79, 80, 98, 102, 216-8  
 Rheumatic fibrositis, 173  
 Ritual, 61, 75, 123, 127, 159, 161-4, 166, 173, drug -, 246, -istic habit, 293, handwashing -, 73, infection -, 162, obsessional -, 104, 158, 161, 190, 265, 275, precautionary -, 22, sleep -, 188, toilet -, 167  
**SACRIFICE**, 164  
 Sadism, 85, 98, 101-2, 129, 154-5, 164-168, 175-6, 179, 191, 193, 196-7, 215, 237-8, 245-250, 257-8, 267, 276, 308, anal -, 41, 191, 217, 256, 275, genital -, 41, 256, - and hostility, 42, infantile - 246, 253, muscle -, 41, oral -, 41, 60, 155, 197, 209, 217, 246, 256, 260, 275, oral and excretory -, 41, 101-2, 104, 246, 256, 260, primary -, 95, unconscious -, 73, 74, 212, 249, 255, 256, 268, 275, 302  
 Sadistic, -instincts, 63, -intercourse, 256, -masochistic couple, 79, 210, 217, 255, 269, -overcharges, 73, -perversion 255, 260, -super-ego, 61, 62, 214, 216  
 Schizoid, -characteristics, 197, 227, 234, 269, -delinquent, 276, -reactions, 104, 168, 300, 307, -subgroups, 278  
 Schizophrenia, 51, 72, 100-1, 130, 131, 148, 183, 193, 195, 202-3, 220, etc., 236, 241, fixation in -, 230, 235, mannerisms in -, 227, paranoid -, 231, 239, subgroups of -, 221, symptom formation in -, 222  
 Schizophrenic, 190, 210, 225-232, -breakdown, 222, 227, -characterformation, 202, -dissociation, 244, -ego, 230, -episodes, 208, 220, -manifestations, 225, 227, 230, 301, -mechanism, 278, -regression, 179, 222-3, 230  
 Secondary elaboration, 88, 115-6, 127, Secondary processes, 53, 68  
 Secretory disturbances, 47  
 Self, -consciousness, 22, conscious -, 23, 57, 234, 277, -depreciation, 46, 61, 226, 272, -inhibition, 26, 74, parent -, 26, 44, 49, -preservation, 29, 34, 40, 43, 46, 47, -punishment (*see Punishment*), -self, 26, 44, 49, fear of -, 23, -hate, 207, -love, 206, -mutilation, 217, 228

Senility, 83  
 Sensory, -function, 284, -end of mental apparatus, 54  
 Sexual, -activities, 252, 270, -adjustment, 81, -attack, 146, 228, bi -, 114, 146, 155-6, 259, 260, -constitution, 237, -delinquency, 265, -displacement, 152, -dysfunction, 244, 250-254, 261, 265, 273, -education, 275, -experiences, 301, -gratification, 181, 252, -guilt, 218, -hygiene, 181, 199, -impulse, 34, 41, 43-4, 48, 73, 92, 162, 172, 229, 234, 278, 313, -inhibition, 41, 42, 254, 269, 299, 321, -intercourse, 114, 258-9, -interest, 234, 255, -mutilation, 116, -perversion, 133, 137-8, 140, 153, 156, 254, 274, 299, 310, -phantasies, 37-8, 63, 162, 164, psycho - (*see Psycho-sexual*), -rivalry, 44, 106, 267, -seduction, 288, -and social, 261, 266, 301, -stimulation, 199, 222, -symbolism, 267, -theories, 37, 154, unconscious - 47, 245, 267  
 Sexuality, adult -, 85, 82, 256, anal -, 44, components of -, 254, dichotomy of -, 263, infantile -, 30, 85, 37, 60, 62, 82, 84, 105, 129, 130-7, 143, 145, 162, 165-6, 193, 210, 246, 250-1, 254, 259, 260, 263, 266-7, 271, 282, 284, 288, 291, 293, precocious -, 105  
 Shame, 154  
 Shell-shock, 176  
 Shyness, 14, 56  
 Skin, 37, 42, -disturbances, 142, 146, -erotism, 210, 219, -experiences, 86, -neurosis, 176, -nucleus, 184  
 Sleep, 39, 82, 99, 115, 125, 175, 178, 180, -disturbances, 185, 187-9, -habits, 187, -lessness, 180, 188, narcissistic state of -, 98, regression in -, 80, 82-3, 110, -and suicide, 216  
 Slips, -of the pen, 118-9, -of the tongue, 118-9  
 Social, -adaptation, 56, 107, 138, 251, 266-7, 270, 272, -anxiety, 105, 285, -curiosity, 78, -delinquency, 274, 293, -difficulties, 264, -disorders -, 260, 264, 317, -habits, 247, -history, 301, -inhibition, 107, 266, 270, 274, -perversion, 132, 133, 266, 274, -and sexual, 62, 83, 266, 285, 302, -shyness, 266-7, a -, 27, 103, 104, 290, anti -, 49, 53, 103-4, 107, anti-characters, 265, 272-4, 290  
 Somatic 173-4, 176, 180, 182, (*see also Psycho-somatic*), -discharge, 183, -factors in schizophrenia, 222, 223  
 Somnambulism, 72, 116, 148, 187-8

Spasm, 183, 195, epileptiform -, 190, habit -, 189

Speech, 87, 102, 118, 159, 179, 192-3, 194, 283, - development, 77, 192, - disorders, 283, organised -, 71, - phobia, 194, power of -, 54, - stereotypy, 227

'Sphincter morality', 60

Stammering, 141, 192, castration and - 194, fixation point in -, 193, 'situation -', 193

STEKEL, 333

Stimulation, 16-7, 46, 48, 54, 124, 159, 171, 184, 223, dangerous -, 228, level of -, 51, 187, neuro-muscular -, 190, over -, 181, 187, 191, 199, psychic -, 33, 81, 83, 191, sensory -, 33, 81, 83, sexual -, 222, traumatic -, 180

Structure, psychic, 15-6

Stupor, 150, 210, 226, catatonic -, 224, pseudo -, 188

Subject/Object, 79

Sublimation, 32, 38, 69, 76, 77, 78, 91, 92, 94, 103, 105, breakdown of -, 79, clinical aspects of -, 78-9, displacement and -, 76, 78, exploitation of -, 241, faulty -, 78, repression and -, 77

Substitution, 90, displacement and -, 77, - of instinct, 25

Suggestion, 148, 199, 200-1

Suicidal, - attempt, 211, 217, - depression, 56, - ideas, 51, - tendencies, 228

Suicide, 42, 61, 207, 215-219, 245, risk of -, 219, safeguard against -, 245, - and self-castration, 217, - and sleep, 216

Super-ego, 38, 57, 58, 64, 89, 71, 102-6, 113, 122, 126-7, 166-7, 186, 210-217, 221, 224, 238, 286, 290, archaic -, 59, 166, atrophy of -, 264, - behaviour, 58, 60-3, 74, 78, 87, 209, conscious -, 57, - and delinquency, 61, - disease, 265, 278, - disorder in psychosis, 204, 211, 241, division of -, 59-62, ego and -, 58, 60, 63-4, 67, 213-4, 218, forerunners of -, 59, - formation, 38, 58-9, 62, 84-5, 100, 105, 106, 209, 230, 237, 294, function of -, 58-64, 70, 226, - hypertrophy, 78, 204, 207, 211, 213-4, 264, hysteric -, 61, - nuclei, 60, 72, 102, 211, 230, 285, - oppression, 229, 242, paranoiac -, 237, 238, primitive -, 61, punishing -, 217, sadistic -, 61-3, 102, 105, 214, 216, structure of -, 59, true genital -, 60

Suppression, conscious -, 70

Symbol formation, 71, 79, 114, 117, 152, 185, phallic -, 114, 145, 246,

259, 267, transference and -, 76, unconscious -, 75, 275, 315

Symbolic, - displacement, 193, - dramatisation, 245, - expression, 152, 196, - love-object, 247, - situation, 234, - thinking, 93, 114,

Symbolism, 114, 116, 120, 130, 145-7, 153-157, 164-5, 179, 188, 192, 208, 212, 217, 222, 225, 228-9, 237, 254-5 259, - and rationalisation, 69, schizophrenic -, 228

Symptom(s), 18, 96, 109, 116, 120, 122, 125, 127-8, 130-1, 137, 140, 142, 146, 148, 149, 156-162, 172, 177, 180-185, 232, 288, 305, 319, etiology of -, 18, hysterical -, 13, 37, 41, 76, 141, 144-5, 168, 169, irrational -, 112, monophasic -, 146, 162, neurotic -, 14, 44-5, 53, 105, 115, 117, 122, 130, 173, 179, 243-4, 280, 299, obsessional -, 75, 164, paranoid -, 231, psychotic -, 14, 44-5, 53, 117, 122, 130, 179, 196, 203, 218, 243, 280, resolution of -, 315, 334, schizophrenic -, 220-1, 225, somatic -, 178, 182, 189

Symptom-formation, 14, 18, 64, 69, 70, 73, 76, 79, 82-3, 96, 109, 116, 119, 122, 123-133, 139, 141, 144, 153, 164, 170, 172, 177, 179, 181, 185, 189, 197-200, 212, 217, 223, 224, 251-2, 264, 268, 277, 287-9, 290, 308, 314, 320, classical -, 243, economics of -, 142, infantile -, 290, 294, level of -, 212, mechanism of -, 209, 222, pattern of -, 139, 142, psycho-neurotic -, 188, 191-2, 250, psychotic -, 209, 223, 240, 242, 274, schizophrenic -, 222

Symptomatic, - acts, 72, 109, 117-8, 120, 122, 125, - habits, 320, mono-formations, 141-2, 156, 240, 320, - reaction, 61, 73, - regression, 126

Syndrome, 139, - in delinquency, 276, etiology of -, 232

Synthesis, 54

TABOO, 22, 47, 70, 153

Tachycardia, 175

Tactile, - stimulus, 54

Tension, 44, 48, 65, 67, 81, 89, 98, 101, 122, 124, 140, 150, 157, 159, 163, 169, 171-2, 174, 178, 182, 186, 195, - affects, 24, 43, 45-7, 58, 62, 187, anxiety -, 187, discharge of -, 48, - dreams, 117, fluctuation of -, 98, instinctual -, 16, 24, 45, 61, 69, 159, 172, 285, mental -, 149, 182, muscular -, 150, sexual -, 47, traumatic -, 233

Terminology, 53, 203

Tic, 189, 190, 191

Topography, 63

Torticollis, 190

Transference, 75, 148, 309, 315, 317, 327, 335, absence of -, 209, alteration in -, 200, - analysis, 199, 316, - in children, 295, - development, 201, emotional -, 200, - formation, 200, 201, 337, incapacity for -, 292, negative -, 309, 316, 327, - neurosis, 86-7, 140, 200-1, 316-7, 329, 333, 334, positive -, 309, 316, 334, - procedure, 148, resistance to -, 336, - situation, 75, spontaneous -, 199, 201, - and symbol formation, 76

Transvestitism, 255, 259

Traumatic, - discharge, 216, 218, - experience, 48, 52, 150, 211-2, 216, 222-3, 237, 239, 240, 242, 304, - frustration, 222, - neurosis, 180, - psychosis, 231 (*see Psychosis*), - reaction, 238, 302, - sensitiveness, 212, - stigmata, 234, - trigger mechanism, 242, - war neurosis, 240

Treatment, 51, 296, 312, duration of -, 319, modification of -, 333, nature of -, 314, recommendation for -, 295, 312, results of -, 330, technique of -, 336

UNCONSCIOUS, - ambivalence, 276, - anxiety, 37, 75, 106, 154, 248, 253, 260, 272, 285, - cathexis, 72, 75, 79, 184, - conflict, 38, 76, 87-9, 101, 174, 183, 244, 250, 266, 300, 306, 318, 320, - conscience, 58, - content, 29, 45, 52-3, 92, 199, - crime, 61, - defence,

225, 240, - and depression, 205, 215, - dramatisation, 197, - ego, 51, 53, 57, 63, 71, 75, - fear, 108, 253, 257, 272, - fixation point, 209, function of -, 57, 200, - hate, 50, 73, 81, 91, 302, - homosexuality, 46, 119, 133, 175, 178, 193, 210, 223, 237, 246-8, 259, 261, 276, - mechanism, 16, 29, 67-9, 209, 251, 255, 265, 271, - mind, 23, 33, 44, 46, - motives, 88, - phantasies, 31, 36, 38, 46, 50, 61, 72, 86, 90, 91, 102, 141, 143, 154, 194, 245, 246, 260, 294, 303, - need for punishment, 42, preconscious and -, 68, 71, - projection, 245, - repression, 70-1, - symbol-formation, 75, 212, 275, 315, - system, 52, 53, 55-6, 63-4, 67-8, 97, 113, - thought processes, 94, 113, 140, 162

Urethral erotism, 35, 60, 100-2, 271

WISH, 116, 126, 146

body -, 114, death -, 155, - formation, 32, 36, 44, 88, frustrated -, 45, 126, 233, - fulfilment, 18, 80, 98, 110, 114, incest -, 94, 145, 153-4, 251, 256, 258, 259, - magic, 230, pleasure -, 238, repressed -, 115, 118, 154, 268

Wit, 89

Word, - formation, 284, - representation, 71

ZONE, anal -, 35, 42, 255, erotogenic -, 38, 172-3, 254-6, 258, genital -, 35, 42, oral -, 35, 42, 155, 255, sexual -, 293, urethral -, 35